IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
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CERTIFIED MAIL: 7000 1670 0011 3314 8910

July 13, 2006

Michael Littman, Administrator
Aspen Park Healthcare
420 Rowe Street
Moscow, ID 83843

Provider #: 135093

Dear Mr. Littman:

On **June 30, 2006**, a Recertification survey was conducted at Aspen Park Healthcare by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. **This survey found the most serious deficiencies to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the attached CMS-2567 whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Date Certain" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.**

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 26, 2006**. Failure to submit an acceptable PoC by **July 26, 2006**, may result in the imposition of civil monetary penalties by **August 15, 2006**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **August 4, 2006 (Date Certain)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **August 4, 2006**. A change in the seriousness of the deficiencies on **August 4, 2006**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 4, 2006** includes the following:

Denial of payment for new admissions effective **September 30, 2006**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 30, 2006**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **June 30, 2006** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf

This request must be received by **July 26, 2006**. If your request for informal dispute resolution is received after **July 26, 2006**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

Loretta Todd

LORETTA TODD, R.N.
Supervisor
Long Term Care

LT/dmj

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135093	A. BUILDING _____ B. WING _____	06/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN PARK HEALTHCARE	420 ROWE ST MOSCOW, ID 83843

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited at the annual recertification survey at your facility. Surveyors conducting the annual survey were: Lory Dayley, RD, Team Coordinator Diane Miller, LCSW Barb Franek, RN, COHN-S Survey Definitions: MDS = Minimum Data Set assessment RAI = Resident Assessment Instrument RAP = Resident Assessment Protocol DON = Director of Nursing LN = Licensed Nurse RN = Registered Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record	F 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Aspen Park Rehabilitation & Healthcare does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. RECEIVED JUL 26 2006 FACILITY STANDARDS **Resident Specific** Resident # 18 and 19 were reviewed by the ID team to ensure her rights as residents in the center were being met. The care plan and grievance forms were updated as indicated. **Other Residents** The executive director (ED) and director of nursing (DNS) reviewed other grievances to ensure proper documentation and that resident rights were being protected. In-service education will be provided to direct care staff and the center's leadership regarding protection of resident rights.	
F 166 SS=D	483.10(f)(2) GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to document resident grievances in a timely manner. Additionally, the facility failed to resolve grievances in such a manner to address violations of resident rights in the resolution. Three grievances were reviewed	F 166		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: M. Karl Littman | TITLE: ED | (X6) DATE: 7/25/06

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 166	Continued From page 1 with one having a satisfactory resolution; one grievance was not signed by the facility as completed and had no documentation of resolution. The third grievance documented resolution steps that failed to address the family's complaint of resident rights having been violated. This deficient practice affected 2 random residents (#s 18 and 19). Findings include: 1. Random resident #19's grievance report, dated 3/7/06, documented the following information: *Documentation of Grievance/Complaint-"Daughter did not feel treatment was timely on skin issue from splint for fx [fracture] of arm. Daughter requests that her mother be sent to ER [emergency room] anytime there is a concern." *Documentation of Facility Follow-Up: See attachments. Attached was a letter dated 3/07/06 addressed to the Administrator of [facility's name] from the resident's daughter who is the resident's Durable Power of Attorney. This letter detailed the following, "...Last Thursday I was informed that [random resident #19] had a sore on her elbow of the broken arm. On Friday I was told it looked bad and that they didn't know how deep the hole went into [random resident #19] elbow. However, they were giving her antibiotics, scraping away the dead skin, and putting something on the wound as directed from phone conversations with [doctor's name] (random resident #19's general MD). When I was visiting [random resident #19] on Saturday, I was told that a nurse was coming in to clean the wound each day over the weekend. However, I saw that [random resident #19's] pain in the affected arm was such that she	F 166	**Facility Systems** Any resident and/or significant other concern is immediately addressed and resolved when possible. Significant concerns are also immediately reported using a written concern/grievance form. The ED or designee reviews the concerns and ensures appropriate follow-up including protection of resident rights when indicated. The resolution is clearly documented on the form. The ED then signs and dates the form when resolution is achieved. Concerns are reviewed and trended by the performance improvement (PI) committee. **Monitor** The ED will review each grievance form and ensure appropriate resolution including protection of resident rights as indicated. Any concern will be addressed immediately and discussed with the PI committee as indicated. **Date of Compliance** August 4, 2006	

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grimaced and winced if the arm was even touched. This began to cause me concern, especially due to the recent surgery on that elbow, so I contacted my siblings. My sister, who has been a registered nurse for 30 years, felt that [random resident #19's] sore on her broken arm needed to be looked at by a physician based upon the information I had at the time."

The letter went on to document, "When I arrived yesterday morning to take [random resident #19] to the ER (since I knew that I couldn't get an appointment with such short notice), your head nurse and the nurse doing the cleaning, told me that it was Monday morning and they hadn't had a chance to look at the wound yet. They requested that I give them a couple of hours to do that. I was also told that there was no need to take someone from your facility to the ER every time something happened to them...All we wanted was for a doctor-not a nurse at your facility-to see this thing. Three hours later I arrived to have your head nurse tell me that since [random resident #19] was on Medicaid, your facility did not want random resident #19] to go to the ER because it would cost your facility and it was unnecessary...In addition, your head nurse began to give me information that conflicted with what the other nurse had previously told me. By this time I was totally frustrated and confused. I will take into consideration your nursing staff's advise, however, I feel the final decision of whether or not [random resident #19] sees a physician for something should be left to me as stated in [random resident #19's] living will (which you have a copy of).

The letter went on to state, "...Your facilities [sic]

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concern over payment for ER visits bothers me and I feel that this is why the above problem occurred. I would like to have a standing order that [random resident #19] is to go to the ER when she falls and complains of pain in any area that your staff feels could even possibly be a broken bone and that I be notified immediately..."

*Resolution of Grievance/Complaint: Was grievance/complaint resolved? The, "YES, describe resolution"box was checked. The description stated, "Educated DNA on using team approach for comm. [communicating] with family. Encouraged dghtr [daughter] to have RN sister call nurse to nurse for info [information]. Educ [educated] dghtr on approp. [appropriate] vs [versus] unnecessary ER visits. Notified staff of dghtr's req [request] for early inter. [intervention]."

The grievance form was signed by the facility's Administrator and dated 3/09/06.

On 6/28/06 at approximately 9:45 am a staff interview was conducted with the DNS regarding this grievance. She stated that the administrator at the time had met with her to discuss the need to use all facility staff to facilitate communication with residents and their families. She stated that possibly in her personnel file there might be documentation of that discussion.

On 6/28/06 at approximately 10:00 am, a staff interview was conducted with the Administrator regarding this grievance. He stated that he would review the DNS's personnel file to see if it documented any information about the DNS's interaction with the previous administrator. He acknowledged that the resolution that was

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documented was not appropriate. He was concerned that it was not focused on the resident's rights and how to protect them. At approximately 1:00 pm, the administrator notified the surveyor that the DNS's personnel file did not document anything regarding resident rights. After further discussion, the administrator stated that he would be meeting with the DNS to discuss the incident and the need to protect resident rights. On 6/28/06 at approximately 1:30 pm, the administrator brought the surveyor a 'Performance Improvement Form' dated 6/28/06 and signed by the DNS and the administrator. The 'Expected Level of Performance' stated, "Associate is required to facilitate and ensure that resident right's are upheld at all times in all situations."

The resolution failed to address the resident's Durable Power of Attorney's complaint that the resident's right to seek medical treatment and to refuse medical treatment had been violated.

2. Random resident #18's grievance report, dated 4/18/06, documented the following information:

*"Describe concern using factual terms: Rsdt [resident] has sent several notes to the nursing director via aide and soc [social worker] stating concerns at controlling his bladder with facility bathroom doors locked, not receiving his pain meds [medications] in a timely manner, and having meal trays left in his room."

*Resolution of Grievance/Complaint - blank

The grievance form was not signed nor dated by the facility's Administrator.

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F 166	Continued From page 5 On 6/28/06 at approximately 1:30 pm, the Administrator brought the surveyor the grievance with the 'Resolution of Grievance/Complaint' section completed. It stated: *"Resolution of Grievance/Complaint: Was grievance/complaint resolved?" The, "YES, describe resolution" box was checked. The description stated, "Facility and rsdt [resident] in contact with Ombudsman. Ombudsman weekly visits through 6/14/06 to mediate various issues including pain management, rsdt communication and coping issues. Rsdt met with OT [occupational therapy] for bladder successful, aide r/t [related to] complaint no longer with facility." The form was signed by the Administrator and dated 6/28/06. The facility failed to ensure that resident grievance resolution was documented, signed and dated.	F 166	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Aspen Park Rehabilitation & Healthcare does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
F 241 SS=E	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations and staff and resident interviews, it was determined the facility did not ensure 8 of 12 sample residents (#'s 1, 4, 5, 6, 8, 10, 11 and 12) and 4 random residents (#'s 14,	F 241	The statement of deficiency incorrectly states that the DNS was observed entering three resident rooms without knocking **Resident Specific** Resident # 8 discharged from the center. The ID team reviewed resident #'s 1, 4, 5, 6, 10, 11, 12, 14, 17, 20, & 21 to ensure they were groomed and dressed in a dignified manner and staff was knocking on	

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F 241	Continued From page 6 17, 20 and 21) were provided care which enhanced their dignity. 1. Residents were awakened and dressed at an early hour for staff convenience. 2. Residents were not provided with personal hygiene care to present a dignified appearance. 3. Staff were observed entering resident rooms without knocking. The findings include: 1. a. On 6/27/06 at 6:50 am, random resident #16 was observed lying on her back in her bed calling out for a staff person to assist her as she needed to go to the bathroom. The surveyor accompanied the CNA into the room and when the CNA pulled back the residents blankets the resident was fully dressed except for her shoes. The CNA was asked why the resident was fully dressed lying in bed. The CNA stated, "The night shift is expected to dress a few residents in order to help the day shift. Resident #16 was dressed at 5:30 am this morning, and returned to bed." b. Resident #12 was observed on 6/27/06 at 7:40 am. She was lying on her back in bed and asleep. She was dressed with her nightgown on and had dress slacks on when the CNA pulled her covers down and indicated they were going to get her up for breakfast. The resident was still asleep with one staff person and a surveyor in the room and the lights on. The surveyor asked the CNA why the resident	F 241	the doors before entering the rooms. Additionally, the ED and DNS rounded in the center to ensure that staff were providing care as directed by the resident's plan of care and not out of convenience for the staff including not awakening residents early to accommodate staff. Where indicated, the plans of care were updated. **Other Residents** As indicated above, in-service education will be provided to address resident dignity. The in-service will include, but not be limited to resident rights and not awakening residents in the morning to accommodate staff, personal hygiene and grooming, and ensuring privacy is respected including knocking on doors before entering rooms. **Facility Systems** Direct care staff receives in-service education and orientation upon hire addressing resident dignity. This training is repeated as indicated. Upon admission, residents are assessed and a plan of care is developed to meet their needs and promote dignity. Based on lifestyle preferences and condition, residents are allowed to awaken at their leisure and receive their meal. Staff will not awaken residents and dress them for their convenience. Staff will knock and be granted permission when indicated before entering a resident's room.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 241	Continued From page 7 had dress slacks on with her nightgown. She stated, "The nightshift gets 5 residents dressed by the end of the shift because we have 20 residents down on the Special Care Unit now." The surveyor asked who the other residents were that got dressed on night shift. She said, "Random resident #16 the night shift had fully dressed and returned to bed. Resident # 1, 3 and 7 the night shift had gotten up and dressed and they were sleeping in the sitting area." She further indicated resident #11 was gotten up at 6:15 am and was sitting at the dining room table waiting for breakfast that would be served at 7:45 am. Resident #1, 3 and 7 were sleeping in recliners in the sitting day area when the surveyor arrived on the Special Care Unit on 6/27/06 at 6:20 am. On 6/28/06 at 10:30 am, a staff interview was conducted with the charge nurse on the Special Care Unit regarding residents being dressed while in bed. She stated that the CNAs had been instructed to get up and dress the residents that had been identified as wanderers. When asked if they were to wake them up she said that they generally get up early without having to be woke up. She had no comment when asked about the residents that were observed lying in bed fully dressed. On 6/28/06 at approximately 3:30 pm, a staff interview was conducted with the DNS during the end of day exit conference. When asked if there was a quota for the number of residents the night shift were expected to have dressed she stated, "I'm not sure it is a quota, however, the CNA's are instructed to get up and dress those residents that have been identified as wanderers. The	F 241	**Monitor** The ED and/or designee will round in the center weekly to ensure resident dignity is being provided. This will include rounding early in the morning to ensure residents are not being awakened for staff convenience. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring as it deems appropriate. **Date of Compliance** August 4, 2006	

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F 241	Continued From page 8 residents are dressed and placed in recliners in the sitting area." 2. a. On 6/29/06 at approximately 8:15 am, random resident #14 was observed at the table in the SCU dining room sleeping with his face in a bowl of oatmeal for several minutes. A couple of staff members walked right by the resident and did not intervene. At approximately 8:20 am, random resident #14 raised his head and had oatmeal on his face. A CNA did at that time clean the oatmeal off of his face. b. Resident #1 was observed on 6/27/06 and 6/28/06 with washable white canvas shoes that had a substance across the entire top of the left shoe that appeared to be cranberry juice. On 6/28/06 at 2:30 pm, the charge nurse on the Special Care Unit was interviewed regarding resident #1's stained shoes. She stated that the CNA should have placed the resident's shoes in the laundry on 6/27/06 after the resident was placed in bed. The charge nurse requested that a CNA go to resident #1's room and retrieve clean shoes so the stained shoes could be placed in the laundry. c. On 6/27/06 at 10:35 am, resident #4 was in the hallway in her wheelchair. Her slacks were observed to be inside out with the seams showing. At 10:40 am, the activity director was observed talking to the resident who was still in the wheelchair located in the hallway. At 11:25 am, the resident was sitting in her wheelchair beside her bed. Her slacks were still inside out. AT 12:40 pm, the resident was observed in the dining room, sitting with other residents. Her	F 241		

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F 241	Continued From page 9 slacks were still inside out with the seams showing. A resident who was out in the hallway during the morning, talking to staff and eating with other residents was not properly dressed. d. During the initial tour at 6:00 pm on 6/26/06, 3 pair of white underpants were observed hanging over the top opening of a plastic basket located under the sink in the room where resident #6 resided. On 6/27/06 at 6:20 am, there were underpants still visible from the open doorway where resident #6 resided. The underpants were draped over the top of a plastic basket. On 6/27/06 at 11:30 am there were 4 pair of underpants draped over the top of a plastic basket. They were visible from the doorway. 3 a. During the tour of the facility on 6/26/06 at approximately 6:15 pm, the DNS was observed entering random resident #17, 20 and 21's rooms without knocking. b. Resident #8 was admitted on 4/14/06 and readmitted on 6/21/06 with a diagnosis of coronary artery disease, congestive heart failure, osteoarthritis, osteoporosis, and depression. On 6/27/06 at 7:35 am during an observation of resident morning cares a CNA was observed to change resident #8's catheter bag to a leg catheter bag. The resident was sitting in her wheelchair in her adult brief when a LN and another CNA opened the residents door wide	F 241		

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F 241	Continued From page 10 without announcing themselves. The resident's privacy curtain was not pulled and she was exposed to a person walking in the hallway. This is a repeat violation from the annual survey of 5/13/05.	F 241	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Aspen Park Rehabilitation & Healthcare does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
F 248 SS=E	483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews and resident interviews it was determined the facility did not provide an ongoing activity program designed to meet the needs and well being for 5 of 12 (#1, 2, 3, 4, 7) sampled residents. The findings include: 1. Resident #2 was admitted to the facility on 4/12/05 with diagnoses of multiple sclerosis and decubitus ulcer. The care plan dated 6/08/06 indicated the resident had been identified with the problems of social isolation related to limited time out of bed or inability to get to activities related to medical diagnosis (decubitus ulcer), diversional activity deficit related to limited time out of bed and depression related to the social isolation. As of 5/14/06, one of the approaches to the activity	F 248	**Resident Specific** The ID team has reviewed resident #'s 1, 2, 3, 4, & 7 related to activity programming to meet their specific needs and well being. The plans of care have been updated to reflect the changes as indicated. **Other Residents** The ID team reviewed other residents related to activities. In-service education was provided to direct care staff related to ensuring participation in activities of the resident's choice and specifically those that were patterned to their specific needs and lifestyle. SCU staff received in-service education on the resources available for 1:1 activities with the residents. Additionally, the training included appropriate documentation.	

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F 248	Continued From page 11 deficit was to have the resident attend bingo at least 1 time per week while up in the wheelchair. The activity progress notes indicated that by 4/21/06, the resident was able to be up for longer periods of time in the wheelchair. The note stated, "has been spending time in her w/c [wheelchair], daily. To encourage socialization she will be eating a meal in the dining room & encouraged to spend time in the common areas of the facility to have opportunities to interact [with] residents & staff." The activity progress note dated 6/05/06, stated, "...Resident is very independent on her activities. Would like to encourage resident to attend more group activities. Resident enjoys reading, watching television and reading her newspaper." There was no mention of attending bingo at least once a week. The April, May and June activity logs were reviewed. The activity logs indicated the resident attended bingo only one time on 4/26/06. The logs did not indicate if the resident was asked and refused to attend bingo. The activity logs indicated the resident was independent with reading the newspaper, watching TV and reading. Self propelling the wheelchair and being in the day areas were also documented as an activity. On 6/27/06 at 10:15 am, the resident was asked what activities she would like to attend. The resident stated, "I don't like to mix but I like bingo." The resident talked about going to bingo and having a good time. She stated, "I won at blackout one time!"	F 248	**Facility Specific** The center will initiate an assessment tool designed to identify the resident's strengths, abilities, lifestyle and desires to address their psychosocial needs. This tool will be the basis of the activity programming specific to each individual resident and development of their individual plan of care. Additionally, the activities/ staff will offer / provide several meaningful activities throughout the day and have access to materials/resources to ensure residents remain engaged in meaningful interactions throughout the day. Staff on the SCU will be provided in-service training by Activity Director elated to activities and on-going meaningful interactions and use of the materials/resources. **Monitor** The ED and/or designee will round in the center at least weekly to monitor for appropriate and meaningful activities to meet the resident's individual needs. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring as it deems appropriate. **Date of Compliance** August 4, 2006	

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On 6/28/06 at 7:30 am, the activity director was interviewed about resident #2. The activity director stated, "the only activity I'm aware she attended was the group exercise and she had to leave to go to physical therapy." The activity director acknowledged she was not aware the resident liked bingo. The activity director stated, "we have bingo once a week, it seems that a lot of residents like that."

A resident who had been socially isolated for a year due to a medical condition was not able to be up for longer periods of time. The interdisciplinary team had identified the social isolation, lack of activities and depression associated with that isolation. One of the interventions was to have the resident attend bingo at least once a week. Yet, the resident had only attended 1 game of bingo over the past 3 months.

2. Resident #4 was admitted to the facility on 12/07/06 with a diagnoses of Alzheimer dementia and diabetes mellitus.

The care plan dated 6/14/06 indicated the problems of impaired thought process and diversional activity deficit related to dementia had been identified. Approaches included encouraging the resident to attend activities that will increase interaction with others, encourage activity program participation and assist to activities of choice, music and socials.

The MDS with the assessment date of 6/09/06 indicated the resident was moderately impaired with decision making and had memory problems.

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The 3/21/06 activity progress note stated, "...participation in sched [scheduled] activities is [decreasing] but she does attend and seems to enjoy bingo. Occasionally attends donut socials, but generally pleasantly declines invitations to participate. enjoys being in her room for privacy..."

The 6/2/06 activity progress note stated, "...Resident is very independent w/her [with her] own agenda. Will continue to encourage attendance."

The activity logs for March, April, May, and June of 2006 indicated the resident generally did independent activities such as reading and television. The resident's ability to self propel the wheelchair was also considered an activity.

Throughout the survey, the resident was observed self propelling in the wheelchair going up and down the 300 hallway. The resident did not appear to have any destination in mind during her travels and at 10:35 am and 11:25 am on 6/27/06 and 8:30 am on 6/28/06, the resident was observed falling asleep in the wheelchair.

On 6/27/06 at approximately 10:20 am, while self propelling the wheelchair on the 300 hallway, the resident was asked what activities she liked to attend. The resident was confused about the question and unable to answer.

The activity director was interviewed at 9:35 am, on 6/28/06 about the activity assessment for self propelling a wheelchair. The activity director stated, "I don't know why it was assessed." The activity director explained that she was new at the

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F 248	Continued From page 14 job and the resident had already been assessed for activity needs. She was not sure why self propelling a wheelchair would be an activity. A resident who was cognitively impaired and whose decision making ability had declined was considered to be independent with her own agenda which consisted of self propelling up and down the hallway, watching TV and reading. 3. On 6/28/06 at 2:30 pm, the surveyors met with 15 residents for a group meeting. During the meeting, at least 5 residents complained of the TV in the day room located at the junction between the 300 and 200 hallway. They stated, "there is too much Mariners baseball on the big screen TV." One female resident stated she would like to watch Lawrence Welk on Saturday evening. Another resident mentioned westerns. The May 2006 calendar indicated that for 14 of 31 days, the Mariners baseball was a listed activity. The June 2006 calendar indicated that for 19 of 31 days, the Mariners baseball was a listed activity. 4. Resident #1 was admitted to the facility on 10/26/05 with diagnoses of Alzheimer's disease, breast neoplasm, osteoporosis and esophageal reflux. The resident's significant change MDS, dated 4/06/06, documented her cognitive status as	F 248		

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F 248	Continued From page 15 moderately impaired with short term and long term memory deficits. The same MDS indicated the resident's mental function varied throughout the day and that she participated in activities less than 1/3 of the time. Activities were one of the areas that triggered on the rap dated 4/10/06. The activities rap documented, "Consider revising activity plan if one or more of the following present: Involved in activities little or none of time-YES." The activities rap went on to identify the following, "Issues to be considered as activity plan is developed: "2. Cognitive status: Yes-short-term memory; Yes-long-term memory; Walking/location pattern: Yes-walk in room; Yes-walk in corridor; Yes-locomotion on unit; Yes-locomotion off unit; Yes-Unstable conditions and Yes-Acute health conditions. The resident's "Initial Activity Assessment" dated 11/01/05 identified that for the resident the following current interests: spiritual/religious, being outdoors, community outings, gardening/plants, singing, parties/social events, western music, educational reading, small talk, children and animals. The resident was not reassessed for her current needs. The resident's care plan, was dated 4/05/06 and included the following documentation: "Diversional activity deficit r/t [related to] impaired thought process as evidenced by: dementia." The goal was identified as, "Will participate in 1:1 interaction and sens [sensory] stim [stimulation] weekly when unable or unwilling to participate in group activities." Approaches included, "Assure awareness of scheduled activities. Provide activity calendar in room...Encourage program participation and praise efforts; assist to activity of	F 248		

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F 248	Continued From page 16 choice: music/socials." The most current activities progress note, dated 5/01/06, documented, "...at the time of her change of condition resident was asleep much of the time and wasn't participating in the activity program due to her decline in function. Sens stem was done with her through touch and scents. Resident seems to be more alert at this time and will be encouraged to participate in the activities of SCU [special care unit]..." The resident was observed on 6/27/06 from 6:15 am until 8:15 am; from 8:35 am until 11:45 am; and from 12:50 am until 2:30 pm and throughout these observations resident #1 was sitting in a recliner in the day area on the SCU with her eyes closed and not moving. On 6/28/06 resident #1 was observed from 8:30 am until 11:30 am, in a recliner in the day area on the SCU with her eyes closed and not moving. Review of the April, May and June 2006 Activity Attendance Record for Resident #1 revealed the following: *For April on a daily basis resident #1 was marked as attending ambulating/self-propel; day areas and music. *For May on a daily basis resident #1 was marked as attending ambulating/self-propel; day areas and music. *For June on a daily basis resident #1 was marked as attending ambulating/self-propel; day areas and music. On 6/28/06 at approximately 11:40 am, a staff interview was conducted with the Activity Director regarding resident #1's activities. She stated,	F 248		

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F 248	Continued From page 17 "Resident #1 requires a lot of 1:1 interaction." I mentioned that the activity attendance log identifies that resident #1 attended on a daily basis 'ambulating/propel'. When asked what that was the Activity Director stated, "That is when the resident walks or propels a wheelchair on the unit." The surveyor inquired how that would be different from normal daily cares that would be provided to a resident and the Activity Director could not identify any difference. The Activity Director defined the attendance at the 'day area' as, "When the resident is present in the day area of the SCU." When asked about what special programming would be present so this could be counted as an activity and she could not identify anything. The surveyor mentioned to the Activity Director that on the SCU is a notebook marked on the binder as 'Activities'. Inside the first page was a letter dated 11/11/05 to the staff of the SCU. This letter documented, "As staff on SCU it is part of your responsibility to make sure the resident's have something to do in the day areas. The cupboards have art supplies, magazines are available, music, TV, good old fashioned talking about anything, reading an article or the newspaper. Any idle time should be spent enhancing your resident's quality of life while in your care. Thank you in advance for your attention to this very important responsibility. Do everything possible to make this the 'fun' part of your day to day job. Give yourself credit for the extra things you do and sign off on these sheets. I'll collect them to add your activities to their flow sheets in my office." The Activity Director was surprised to hear of this binder. She stated that she had not found any completed sheets in her office. Review of the binder revealed many blank	F 248		

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F 248	Continued From page 18 sheets with none having any information documented on them. The Activity Director stated that music was defined as, "When staff turn music on while residents are sitting in the day room during breakfast. The music plays in the background the majority of the day." She acknowledged that it isn't special music instead soothing CD's, etc. On 6/28/06 at approximately 12:30 pm, a staff interview was conducted with the facility Administrator regarding activities on the SCU. The Administrator stated, "It is way too quiet on the SCU. I know that this is an area that needs some focused attention. On Friday I just may give away the recliners in the day area on the SCU that belong to the facility to hopefully get some action instead of residents sleeping in them." The facility failed to provide activites for residents on the SCU that were designed to meet their needs in accordance with the comprehensive assessments related to their interests and physical conditions. There were similar findings for resident #3 and #7 on the special care unit.	F 248		

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F 257 SS=E	483.15(h)(6) ENVIRONMENT- TEMPERATURE The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, and family interviews, it was determined the facility did not ensure that the ambient indoor temperature was maintained within a comfortable and safe temperature level. This affected 1 of 12 sampled residents (#9), 1 random resident (#15), and all other residents who resided on the 300 and 100 units. The findings include: The 2003 Centers for Disease Control and Prevention (CDC), "Guidelines for Environmental Infection Control in Health-Care Facilities," page 217, recommended that the ambient temperature for a resident's room in a nursing home be maintained between 70 - 75 degrees Farenheit (F) with a relative humidity between 30 - 60 %. The temperature range was based on the American Institute of Architects 2001 guidelines. The 2001 American Society of Heating, Refrigeration, Air conditioning Engineers recommended a design point of 75 degrees with 50% relative humidity (55 degrees dewpoint) for a nursing home. But the author of the ASHRAE "Humidity Design Guide for Commercial and Institutional Buildings," had suggested that the 75 degrees with 50% relative humidity design point may not be appropriate for a nursing home and that,"78 degrees with a dewpoint of 50 degrees might be a more suitable condition." This was	F 257	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Aspen Park Rehabilitation & Healthcare does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. **Resident Specific** On this date, the community experienced record heat. When a concern was identified, immediate action was taken for repair and comfort of the residents. Specifically, resident #'s 9 & 15 were offered fans and expressed their comfort and satisfaction. **Other Residents** On this date, the center initiated its Warm Weather Hydration Protocol to ensure adequate hydration and comfort for the residents. Residents were provided a fan at their request and if the room temperature was noticeably warm. In-service education was provided on the protocol as stated in the statement of deficiency. Repairs were made quickly and efficiently as needed. The PI committee discussed necessary provisions in the event of air conditioning failure including securing adequate fans for comfort.	

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F 257	Continued From page 20 based on the attempt to balance the metabolic needs of the elderly and the increased work activity of the staff. For all facilities certified after 10/01/90, the Centers for Medicare and Medicaid (CMS) required the ambient temperature to be maintained between 71 - 81 degrees F, with no mention of dewpoint or relative humidity. CMS required, all facilities certified on or before 10/01/06, to maintain safe and comfortable temperature levels. During the initial tour at approximately 6:15 pm, on 6/26/06, resident #9 stated, "It's hot in here." At that time, the resident was using a pedestal type oscillating fan. When asked how long it had been hot in the facility, the resident was not sure. At approximately 6:30 pm, random resident #15 was in her room with a small fan operating. The fan was attached to the bedside table, next to the bed. When asked if the small fan was keeping her cool, the resident stated, "It's OK." The resident indicated the facility had been hot most of the day. When asked if the facility had provided the fan, the resident stated, "No, I brought this from home." A surveyor had started to check the ambient temperature in the 100 hall at approximately 6:30 pm. The temperature on the 100 hallway, dining/activity room and the library was 86 degrees F. The 200 hall was noticeably cooler both in the hallway and in residents rooms. The ambient temperature throughout the 300 hall was also found to be 86 degrees F. The thermometer was set up in resident #9's room at approximately 6:45 pm. The temperature was 86 degrees F. The	F 257	**Facility Systems** The center initiated the Warm Weather Hydration Protocol as noted above. In-service education will be provided at least annually prior to warm weather months. **Monitor** Maintenance or designee will monitor for appropriate temperatures during appropriate seasons and document results. PI committee will follow and address any concerns. **Date of Compliance** August 4, 2006	

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thermometer was re-checked at 7:15 pm and remained at 86 degrees F.

At approximately 7:00 pm on 6/26/06, the administrator stated, "I've called an air conditioner repair man." The administrator explained that the maintenance man had been working on the air conditioner all day and that he thought it was fixed. When the survey team exited the facility at 7:30 pm, the air conditioning repair man had arrived and was working on the problem.

On 6/27/06 at 1:30 pm, resident #9 complained of her room being too hot. A thermometer was set up in her room, on the sink counter. It measured 79 degrees F.

On 6/27/06 at 1:40 pm, the maintenance man was observed measuring temperatures in the 300 hallway. At the air conditioning vents the temperature was 66 degrees F. The temperature at the ceiling level, near the residents rooms was 78 degrees. The floor temperature obtained by the maintenance man was 73 - 75 degrees. The maintenance man stated, "I have cold air coming out of the ducts but it's not getting into the rooms." The maintenance man explained that the air conditioning vents on the 300 and 100 hallways did not have diffusers while the 200 hall vents did have the diffusers. The maintenance man felt that may be one of the reasons the rooms and hallway on the 200 hall stayed cool.

On 6/27/06 at 1:55 pm, the temperature in resident #9's room was 80 degrees F.

On 6/27/06 at approximately 2:00 pm, a surveyor was told there was a water leak in the physical

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135093	A. BUILDING _____ B. WING _____	06/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN PARK HEALTHCARE	420 ROWE ST MOSCOW, ID 83843

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 257	Continued From page 22 therapy (PT) department and went to check it out. A ceiling tile was observed to be removed and a step ladder was set up under the open ceiling area. The Physical Therapist was asked about the leak. He explained the leak was from the air conditioner. He stated, "something happened to a coil. I guess it froze up. he [maintenance man] said it was OK to turn it on." On 6/27/06 at 2:35 pm, the ambient temperature in resident #9's room was 81 degrees F. A family member was visiting the resident at that time. The family member told the surveyor he was worried about the heat in the room. The family member stated, "I bought this fan and I call them and tell them to turn it on." The family member stated the resident had been at the facility since May. A review of the record indicated the resident was admitted to the facility on 5/10/06. On 6/27/06 at 3:00 pm, the ambient temperature measured 81 degrees F throughout the 300 hallway, at the 300 hall nurses station, the sitting area near the 300 hall nurses station, the entire 100 hallway, and the dining/activity room on the 100 hall. At least 4 residents were observed to be sitting in the 100 hall dining/activity room at that time. The facility's thermometer, located at the sitting area near the 300 hall nurses station also registered 81 degrees F. The maintenance man was interviewed at approximately 3:00 pm on 6/27/06, he stated, "the coils have froze up." The maintenance man explained that it had happened twice this afternoon.	F 257		

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F 257	Continued From page 23 On 6/27/06 at approximately 7:00 am and again at approximately 3:15 pm, the administrator was asked to provide a policy/procedure concerning the plan of action to prevent heat related problems when the air conditioner failed. On 6/28/06 at 7:25 am, the administrator did not have the policy to provide to the survey team but verbally explained the policy. The administrator stated, "We have a hydration policy and offer fluids." The administrator went on to explain that if the temperature exceeded 81 degrees F, the residents would be moved to a cooler area. He stated, "We can move them to a cooler place like the dining room." The administrator did not answer when surveyors asked, "what if the dining room is hot? and what do you do when it gets hot during the evening and residents want to go to bed?" When asked how many fans the facility had available to provide to residents, the administrator stated, "We have 4 fans." After stating 4 fans were available, the administrator stated, "I don't really know how many we have." On 6/28/06 at 12:10 pm, the facility's "Warm Weather Hydration Protocol," was provided to the survey team. Attached to the protocol was a training roster dated 6/27/06. The roster had been signed by 4 LNs, including the DON, a housekeeping supervisor, and the person doing the training. Also attached to the protocol was a fan inventory dated 6/28/06. The inventory indicated there were 43 fans available in the facility. On 6/28/06 at 2:30 pm, the group meeting with the residents was conducted. The meeting was attended by 15 residents. When asked about the temperature of the facility, 3 residents, who wish	F 257		

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F 257	Continued From page 24 to remain anonymous, indicated it was "hot and stuffy." The 3 residents resided on the 300 hallway. When asked if the facility had offered fans, they stated, "No we weren't offered fans." Residents on 2 of 3 hallways were hot and uncomfortable while the facility air conditioner required repair.	F 257	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Aspen Park Rehabilitation & Healthcare does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interview, and staff interviews, it was determined that care plans were not revised for 3 of 12 (#2, 9,	F 280	**Resident Specific** Resident # 8 has discharged from the center. The ID team reviewed resident #'s 2 & 9 related to care plan documentation. Resident # 2 did not have window air conditioner replaced in her room per her request. Resident # 9 continues to be weighed as noted in the statement of deficiency. These interventions have been added to the plan of care. **Other Residents** The ID team reviewed other residents related to their plans of care and needs. Newly admitted residents were reviewed to ensure specific interventions were included on the initial plan of care to address specific identified risks. In-service education will be provided to licensed nurses (LN) regarding care plan documentation and monitoring at the bedside. The ID team will	

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F 280	Continued From page 25 and 8) sampled residents. The findings include: 1. Resident #2 was admitted to the facility on 4/12/05 with diagnoses of multiple sclerosis (MS) and decubitus ulcer. a. The care plan dated 6/08/06, indicated the resident had been identified as having a problem with skin integrity in 2 different areas of the care plan. Problem area #5 stated, "Keep pulled up in bed so feet don't touch bottom of specialty mattress." Problem area #9 stated, "Use positioning & pressure relieving device (specify)." The only device specified was a "specialty bed." On 6/27/06 at 6:25 am and 7:00 am, the resident was observed to have both feet in foam lift boots with the heels floating. In addition to the foam lift boots, the feet were also lifted with a pillow. b. The care plan dated 6/08/06, indicated the resident had been identified with the problem of "Hypermetabolic state R/T [related to] MS." The approach section of the care plan stated, "Air conditioner in room." The problem and the approach were dated 10/04/05. During the initial tour of the facility on 6/26/06, at approximately 6:30 pm, the resident was observed to have an oscillating fan in the room. The fan was not in use. During subsequent visits to the room, an air conditioner was not observed in the room. On 6/28/06 at 10:45 am, the resident was asked about the air conditioner. The resident stated, "they will put one in the window. I have a fan for now." A housekeeping person was standing in the doorway and stated, "the air conditioner had to be taken out in the winter and	F 280	review resident care plans in-depth at their next quarterly review or significant change of condition to ensure adequate detail and implementation at the bedside. **Facility Systems** Residents are assessed upon admission and at least quarterly. Based on the assessments, the plan of care is developed and documented. The plan of care is maintained current with the resident's changes in their status. Specific interventions are documented and carried out at the bedside. The ID team will review the care plan at least quarterly to ensure accuracy and completeness. **Monitor** The DNS and/or designee will review at least two resident care plans weekly to ensure accuracy and completeness. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of monitoring as it deems appropriate. **Date of Compliance** August 4, 2006	

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F 280	Continued From page 26	F 280		

hasn't been put back in yet." The housekeeper explained that cold air was coming into the room around the air conditioner during the winter months.

2. Resident #9 was admitted to the facility on 5/10/06 with diagnoses of Alzheimer dementia and atrial fibrillation.

The initial care plan with a date of 12/19/00, indicated the resident had a problem of weight loss. The initial care plan was a master, generic care plan which covered multiple problems and multiple approaches. The staff either circled problems and approaches or wrote the information on the generic care plan. The following problem was hand written, "Weight loss of 10 lbs [pounds] since admission." The section of the care plan dedicated to approaches for a problem had 10 approaches listed. Only 3 were circled and none addressed weighing the resident.

The care plan dated 6/02/06, indicated the resident had a problem of dehydration related to a decreased appetite. None of the approaches included weighing the resident.

The review of the nutrition progress notes indicated the resident was being weighed frequently. The 6/15/06 note stated, "Res[ident] triggered for sig[nificant] wt [weight] [decrease] x 30 days...to continue monitoring weight trend."

On 6/29/06 at 9:30 am, the DON was interviewed concerning the weight loss and the frequency of the weights. The DON stated, "all Medicare patients are weighed weekly." The DON was not

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F 280	Continued From page 27 sure why it was not care planned. The care plans were the road map designed to provide all healthcare providers with the information they would need to take care of the residents. Inaccurate care plans do not communicate the needed information staff required. 3. Resident #8 was admitted to the facility on 4/14/06 and readmitted on 6/21/06 with the diagnoses of coronary artery disease, congestive heart failure, osteoarthritis, osteoporosis, cataracts and depression. The resident's initial MDS, dated 4/21/06, indicated the resident required extensive assistance of one staff for bed mobility, transfers, dressing, toileting, personal hygiene and bathing. A fall risk assessment dated 6/21/06, documented resident #8 with a fall risk score of 32 (14 plus high risk). The resident's care plan, dated 6/22/06, did not have any interventions for the prevention of falls. From 6/27/06 though 6/28/06 the resident was observed several times to have a pressure alarm on her bed and her bed in a low position. On 5/4/06 at 9:35 am, the DON was informed of the surveyor's observations of resident #8 with a pressure alarm in her bed and her bed in a low position. The DON indicated that it was not care planned because these interventions were put into place for all residents once admitted into the	F 280		

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F 280	Continued From page 28 facility. This is a repeat violation from the annual survey of 5/13/05.	F 280	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Aspen Park Rehabilitation & Healthcare does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure services provided or arranged by the facility met professional standards of quality to include ensuring physician orders were clarified regarding duplicate antibiotic therapy, start and ending dates of antibiotic treatment and that medications were not left out and unattended. This affected 1 of 9 sampled residents (#1) whose medication was not administered per physician orders and 1 of 4 (#22) residents observed during the medication pass. The findings include: 1. Resident #1 was admitted to the facility on 10/26/05 with diagnoses which included Alzheimer's disease, breast neoplasm, osteoporosis and esophageal reflux disorder. The May 2006 MAR [medication administration record] documented the resident was to be administered Levaquin 250 mg x 9 days for a UTI [urinary tract infection]. The Levaquin was documented as given May 23 through May 31st.	F 281	**Resident Specifics** The ID team reviewed resident #'s 1 & 22 related to medications. The antibiotic order was clarified and was not administered as it was a transcription error and not intended for this resident. The nurse mentioned in the statement of deficiency was inserviced on ensuring medications are secured. **Other Residents** The ID team reviewed other residents related to medication administration. In-service education was provided to LN staff related to medication administration including securing medications when unattended and verifying orders for clarity when indicated.	

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F 281	Continued From page 29 There was a follow up UA [urinalysis] ordered 7 days after treatment which was indicated as 6/7/06. Review of the resident's record revealed a physician's recapitulation order for 6/01/06 through 6/30/06. The recapitulation order documented, "Order date 5/19/06, Cipro 250 mg po [by mouth] daily x [times] 10 d [days] (UTI)." The D/C [discontinue] date was identified as 6/06/06 and should have been 5/30/06. The recapitulation order for Cipro was documented on the June 2006 MAR with an order date of 5/19/06 and a discontinue date of 6/06/06 for resident #1. Review of this MAR for resident #1 revealed that she was not administered the Cipro medication at all in the month of June. The facility should have questioned why the resident was being prescribed two different antibiotics for a UTI at the same time. Additionally, the facility should have verified with the physician the start and ending dates of the Cipro. On 6/28/06 at approximately 10:00 am a staff interview was conducted with the charge nurse on the Special Care Unit. She stated, "I'm not sure why the Cipro medication was not administered to resident #1 in the month of June." She said that she vaguely remembered something about one medication being discontinued and another being ordered. She agreed to research it further and provide the surveyor with additional information when she obtained it. No further information was provided to the surveyor before the end of the survey.	F 281	**Facility Systems** Physician orders are reviewed monthly by LN staff to ensure accuracy and then sent to the physician for signature. When indicated, orders will be clarified and well documented. The medical records director will process orders and print the administration records timely for LN staff to complete final reviews. Additionally, the DNS and/or designee will complete competency checks for LN staff annually to ensure competency with medication administration. **Monitor** The DNS and/or designee will observe at least one LN per week to ensure competency with medication administration. This will include, but not be limited to ensuring orders are clear and accurate and medications are secured when unattended. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring as it deems appropriated. **Date of Compliance** August 4, 2006	

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F 281	Continued From page 30 The facility failed to clarify with the physician the appropriate antibiotic treatment and start/stop dates of the medications. 2. On 6/27/06 at 7:47 am, the LN passing out medications on the 200 hallway, was observed removing a ziplock bag with a bottle of Alphagan eye drops from the medication cart and setting it on top of the cart. The eye drops were later administered to resident #22. The LN walked away from the cart to retrieve a protein shake for a resident. The eye drop bottle was left on top of the cart. The LN returned to the cart at 7:55 am. For 8 minutes the eye drops were left out, on top of the cart.	F 281	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Aspen Park Rehabilitation & Healthcare does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
F 312 SS=E	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure residents who required assistance with eating and bathing received the necessary assistance. This was true for 4 of 12 sampled residents (#'s 1, 3, 5 & 7) for bathing and 8 of 12 sampled residents (#'s 1, 3, 5, 7, 10, 11, & 12) for eating. Findings include: Bath Records:	F 312	**Resident Specific** The ID team reviewed resident #'s 1, 3, 5, & 7 related to bathing assistance. These residents were observed to be clean and well groomed. Further, the ID team reviewed resident #'s 1, 3, 5, 7, 10, 11, & 12 related to eating assistance and meal monitoring. Adjustments to the plans of care were completed as indicated. **Other Residents** The DNS rounded in the center and observed bathing and meals of other residents. In-service education will be	

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F 312	Continued From page 31 1. Resident #3 was admitted to the facility on 07/30/04 with diagnoses including progressive supranuclear palsy, parkinson's disease, hypothyroidism and dementia. The quarterly MDS dated 06/05/06, documented that resident #3 was moderately impaired-decisions poor; cues/supervision under cognition. Under bathing resident #7 was identified as total dependence. Resident #3's bath records were reviewed for the months of May and June, 2006. The resident's record identified the resident was care planned to receive, "...Shampoo, shower/bath: specify 2 times a week..." Review of the resident's shower schedule documented the resident was to receive a shower on Friday and Tuesday each week. *A shower was performed on 5/09/06. The resident did not receive a shower again until 5/19/06, ten days later. *The resident received a shower again on 5/23/06, four days later. *The resident's next shower cares were performed on 5/30/06, seven days later. *The resident received a shower on 6/02/06. The next bathing cares were performed on 6/13/06, eleven days later. 2. Resident #7 was admitted to the facility on 7/18/02 with diagnoses including dementia and cerebrovascular accident. The quarterly MDS dated 06/05/06, documented that resident #7 was severely impaired-never/rarely made decisions under cognition. Under bathing resident #7 was identified as total dependence.	F 312	provided to direct care staff related to completing and timely recording baths as well as providing assistance and cueing during meals as indicated on the plans of care. Additionally, training will be provided to direct care staff related to proper meal monitoring including documentation and offering alternatives when food is refused or poorly taken. **Facility Systems** Residents are assessed upon admission, quarterly and with any significant change of condition related to assistance required with activities of daily living. Bathing schedules are arranged based on resident needs and preferences and usually provided at least twice weekly – more often if indicated or desired. Baths are completed and documented accordingly. Additionally, residents are assessed for required assistance for meals. The plan of care is developed as indicated. Resident meal intake is monitored and recorded. When indicated, alternatives are offered to residents to encourage adequate intake. If a resident has consistent poor intake, the ID team reviews for potential changes in the plan of care. LN staff supervises to ensure adequate assistance is provided and care is documented required. **Monitor** The DNS and/or designee will observe activities of daily living including bathing and meal service to ensure adequate assistance is provided per the plan of care.	

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F 312	Continued From page 32 Resident #7's bath records were reviewed for the months of April, May and June, 2006. The resident's record identified the resident was care planned to receive, "...Shower 2x [times] week..." Review of the resident's shower schedule documented the resident was to receive a shower on Wednesday and Sunday each week. *The resident was showered on 4/22/06. The resident did not receive a shower again until 5/03/06, eleven days later. *The resident was next showered on 5/10/06, seven days later. *The resident was showered on 5/17/06, and her next shower was on 5/24/06, seven days later. *The resident was next showered on 5/28/06, and was not showered again until 6/11/06, fourteen days later. *The resident was showered on 6/21/06, and as of 6/28/06 had not been showered again, seven days later. 3. Resident #5 was admitted to the facility on 11/8/04 with the diagnoses of hypernatremia, Alzheimer, arthritis, hypertension, and hypothyroidism. The annual MDS assessment, dated 6/14/06, indicated the resident was moderately impaired cognitively and required extensive assistance of one person for bed mobility, transfer, dressing, hygiene and required extensive assistance of two people for bathing. The resident also required supervision for eating. There was no care plan found addressing how often the resident was to be bathed.	F 312	Additionally, the records will be reviewed to ensure timely and accurate documentation. Any concerns will be addressed immediately and discussed the PI committee as indicated. The PI committee may adjust the frequency of the monitoring as deemed appropriate. **Date of Compliance** August 4, 2006	

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F 312	Continued From page 33 Resident # 5's flow sheet record was reviewed and documented that from June 1st though June 11th and June 20th though June 30th the resident was not given a shower or bath. On 6/28/06 at 11:30 am, the DON acknowledged that the resident had nothing care planned for bathing and that if it was not recorded as given then it probably did not occur. The facility failed to provide residents needing assistance with showers or bathes services according to their care plans. Eating Assistance: 1. Resident #7 was admitted to the facility on 7/18/02 with diagnoses including dementia and cerebrovascular accident. The quarterly MDS dated 06/05/06, documented that resident #7 was severely impaired-never/rarely made decisions under cognition. Under eating resident #7 was identified as needing limited assistance with one person physical assistance. The care plan dated 02/02/05 detailed a problem area as, "self-care deficit: eating r/t [related to] cognitive impairment." The goal for this problem area was, "Will feed self with mod [moderate] assist." Approaches for this problem area included, "...Verbal/physical cueing to remind resident to use utensils; Allow time to feed self supervise with prompting and verbal cueing, assist as needed to complete task. Verbal cue to pace eating and chew foods.; Encourage multiple swallows during meals. Decrease rate of eating."	F 312		

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	135093	A. BUILDING _____ B. WING _____	06/30/2006

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F 312	Continued From page 34 Observation occurred on 6/27/06 from approximately 8:10 am until 8:35 am during which time resident #7 was eating breakfast. At 8:15 am, resident #7 had her eyes closed and was not engaged in eating. A staff person was observed saying resident #7's name to cue her to eat. Resident #7 was observed taking a couple more bites of food and then again was observed with her eyes closed and not eating. During the twenty five minute observation, this was the only cueing and/or assistance that was given to resident #7. Staff removed resident #7's food from the table without offering her any assistance with eating. The facility did not offer the resident a replacement meal even though she had consumed less than 50% of the meal. On 6/27/06 from approximately 12:35 pm until 1:10 pm, resident #7 was observed during the lunch meal. At no time during this observation did staff provide any cueing or assistance to resident #7. Resident #7 was observed to have eaten 100% of this meal. On 6/28/06 from approximately 8:10 am until 8:45 am, resident #7 was observed during the breakfast meal. Staff were observed saying resident #7's name on two occasions. One was when she was observed with her eyes closed and not engaged in eating. The other was when resident #7 was observed rhythmically tapping her spoon on the bowl that was in front of her and was empty. Staff realized that she was signaling to them that she wanted more to eat so they gave her another bowl. Staff did not assist the resident with cueing or assistance as care planned.	F 312		

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F 312	Continued From page 35 2. Resident #1 was admitted to the facility on 10/26/05 with diagnoses including Alzheimer's disease, breast neoplasm, osteoporosis and esophageal reflux disorder. The quarterly MDS dated 4/06/06, documented that resident #1 was moderately impaired-decisions poor; cues/supervision under cognition. Under eating resident #1 was defined as, "extensive assistance with one person physical assist. Review of the 'Medical nutrition therapy assessment' dated 4/07/06, stated, "...Res [resident] receives assistance with meals..." The dining location was identified as, "SCU [special care unit] dr [dining room] with assistance." Under the dining skills section the box for extensive assistance was checked. The care plan dated 11/08/05, identified a problem area as, "nutrition r/t [related to] alzheimer's r/t disease process (specify) cancer." Goals for this problem area included, "...Will consume 75% of meals." Approaches included, "To eat in SCU dining room. Assist as needed to complete meal; encourage to drink all fluids on meal tray..." Another problem area was identified as, "SLP [speech language professional] plan of care r/t dysphagia." The goal was identified as, "Will be free from choking, without s/s [signs or symptoms] of aspiration while managing appropriate diet: regular, thin liquids." Approaches for this problem included, "...Cue resident to use the following swallowing facilitators: sm [small] bites/sips; chew thoroughly; multiple swallow..."	F 312		

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F 312	Continued From page 36 On 6/27/06 from 7:50 am until approximately 8:25 am, resident #1 was observed sitting at a table in the SCU having breakfast. Resident #1 was observed eating approximately 25% of the meal prior to walking away from the table. At no time during the above observation did staff offer any assistance to resident #1. Even though she ate only 25% of her meal no staff encouraged her to drink the fluids on her tray or to eat more of the meal. On 6/27/06 from 12:05 pm, until approximately 12:45 pm resident #1 was observed during the lunch meal. After staff delivered the lunch tray to resident #1 they did not provide any assistance or cueing to her. At 12:45 pm, resident #1 was observed leaving the table after having consumed approximately 25% of the meal and not drinking all of her fluids. Staff did not attempt to encourage her to eat more of her lunch or to drink the fluids. On 6/28/06 from approximately 7:40 am until 8:30 am, resident #1 was observed during the breakfast meal. At approximately 8:10 am resident #1 was observed getting up from the table and telling a nearby staff person that she had to use the restroom. At 8:17 am, staff were observed escorting resident #1 back to the table after having assisted her to the restroom. Resident #1 was observed to have consumed 100% of her meal. After staff removed her tray from her, she was brought a cup of coffee. Resident #1 was observed to choke while drinking coffee at approximately 8:45 am and again at 8:50 am. Staff did not provide resident #1 with cueing according to her care plan regarding her history of	F 312		

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F 312	Continued From page 37 difficulty with swallowing. Instead the charge nurse was heard stating, "Oh, that is just the respiratory disorder that she has been having difficulty with." On 6/28/06 at approximately 10:00 am, a staff interview was conducted with the charge nurse on the Special Care Unit regarding resident #1's care plan for assistance and cueing with eating. The charge nurse reported that for awhile resident #1 did require assistance with eating, however, now she is independent with her eating. The incident of the resident choking on her coffee was discussed with the charge nurse. The surveyor showed the charge nurse the care plan for the resident to be cued so that she didn't have difficulty with swallowing or potential aspiration. The charge nurse appeared to be surprised that this was part of resident #1's care plan. Staff did not assist the resident with cueing or assistance as care planned. Replacement Meals: 1. Resident #10 was admitted to the facility on 10/01/99 with diagnoses including dementia, CVA [cerebrovascular accident] with r [right] side weakness, and atrial fibrillation. The care plan dated 1/18/05, documented a problem area as, "Routine care needs provided by non-licensed staff: moderately impaired daily decision making skills, supervision and cueing needed with daily cares, meals and activities r/t [related to] dementia. One of the approaches documented, "...monitor and record % of all meals, offer replacement if resident eats 75% or less (record % of replacement)..."	F 312		

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F 312	Continued From page 38 The 'Meal Monitor Flow Sheet Record' documented a nursing order, "Monitor and record % [percentage] of all meals. Offer replacement if rsdt [resident] eats 75% or less. Record % [percentage] of replacement." The 'Meal Monitor Flow Sheet Record' for April, May and June 2006, were reviewed for resident #10. *The month of April resident #10 had 37 meals where she consumed less than 75% of her meal and she was not offered a meal replacement. *The month of May resident #10 had 52 meals where she consumed less than 75% of her meal and she was not offered a meal replacement. *The month of June resident #10 had 68 meals where she consumed less than 75% of her meal and she was not offered a meal replacement. The facility did not follow the nursing order regarding replacement meals to be offered if 75% or less of the meal was consumed. 2. Resident #11 was admitted to the facility on 7/08/05 with diagnoses including dementia, osteopenia, breast neoplasm and lactose intolerance. The 'Meal Monitor Flow Sheet Record' documented a nursing order, "Monitor and record % [percentage] of all meals. Offer replacement if rsdt [resident] eats 50% or less. Record % of replacement." The 'Meal Monitor Flow Sheet Record' for April, May and June 2006, were reviewed for resident #11.	F 312		

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F 312	Continued From page 39 *The month of April resident #11 had 30 meals where she consumed less than 50% of her meal and she was not offered a meal replacement. *The month of May resident #11 had 57 meals where she consumed less than 50% of her meal and she was not offered a meal replacement. *The month of June resident #11 had 61 meals where she consumed less than 50% of her meal and she was not offered a meal replacement. The facility did not follow the nursing order regarding replacement meals to be offered if 50% or less of the meal was consumed. 3. Resident #1 was admitted to the facility on 10/26/05 with diagnoses including Alzheimer's disease, breast neoplasm, osteoporosis and esophageal reflux disorder. The 'Meal Monitor Flow Sheet Record' documented a nursing order, "Monitor and record % [percentage] of all meals. Offer replacement if rsdt [resident] eats 50% or less. Record % of replacement." The 'Meal Monitor Flow Sheet Record' for April, May and June 2006, were reviewed for resident #1. *The month of April resident #1 had 14 meals where she consumed less than 50% of her meal and she was not offered a meal replacement. *The month of May resident #1 had 15 meals where she consumed less than 50% of her meal and she was not offered a meal replacement. *The month of June resident #1 had 20 meals where she consumed less than 50% of her meal and she was not offered a meal replacement.	F 312		

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F 312	Continued From page 40 The facility did not follow the nursing order regarding replacement meals to be offered if 50% or less of the meal was consumed. 4. Resident #12 was admitted to the facility on 10/02/00 with diagnoses including alzheimer's and mental disorder not otherwise specified. The 'Meal Monitor Flow Sheet Record' documented a nursing order, "Monitor and record % [percentage] of all meals. Offer replacement if rsdt [resident] eats 50% or less. Record % of replacement." The 'Meal Monitor Flow Sheet Record' for April, May and June 2006, were reviewed for resident #12. *The month of April resident #12 had 26 meals where she consumed less than 50% of her meal and she was not offered a meal replacement. *The month of May resident #12 had 33 meals where she consumed less than 50% of her meal and she was not offered a meal replacement. *The month of June resident #12 had 19 meals where she consumed less than 50% of her meal and she was not offered a meal replacement. The facility did not follow the nursing order regarding replacement meals to be offered if 50% or less of the meal was consumed. There were similar findings for resident #3, 5 and 7.	F 312		

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F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review it was determined the facility did not ensure that the care plan to prevent pressure sores was followed for 1 of 2 sampled residents (#3) who had a history of pressure sores. Findings include: 1. Resident #3 was admitted to the facility on 8/11/04 with diagnoses of Parkinson's disease, dementia with behavior disturbance and hypothyroidism. The resident's quarterly MDS, dated 3/15/06, documented the resident as moderately cognitively impaired, required total assistance for transfers and total assistance for ambulation outside of her room. The MDS documented 1 Stage 1 pressure ulcer. In addition, the facility had a "Pressure Ulcer Risk Assessment Tool" dated 3/08/06 that documented the resident as 14 meaning that she was at "Moderate Risk" for pressure sore risk. "Weekly Pressure Ulcer Condition Report" dated 5/23/06, documented that the resident had no	F 314	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Aspen Park Rehabilitation & Healthcare does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. **Resident Specific** The ID team reviewed resident # 3 related to pressure sore prevention. The resident's skin was intact. Direct care staff was counseled regarding the resident's plan of care that indicated that she be in the wheel chair for meals only. The care plan has been updated to allow for the resident to be up in wheel chair for meals and in recliner as she requests. **Other Residents** The ID team rounded in the center to ensure that preventative measures were in place for other residents noted to be at risk for pressure sore development. Direct care staff will receive in-service education related to skin care and pressure sore prevention. **Facility Systems**	

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F 314	Continued From page 42 pressure sores at that time. The care plan dated 3/02/06, documented, "Skin Integrity Impaired, skin integrity will be restored and maintained." One of the interventions stated, "Up in W/C [wheelchair] for meals only, to be in recliner or bed when up to protect skin." The resident was observed on 6/27 at 10:15 am, 11:00 am, 12:55 pm, 1:10 pm, 2:00 pm, and 2:30 pm each time sleeping in her wheelchair in her room. On 6/28/06 at 9:50 am, 10:30 am and 11:20 am each time sleeping in her wheelchair in her room. On 6/28/06 at approximately 10:30 am a staff interview was conducted with the charge nurse on the Special Care Unit regarding resident #3's care plan. She acknowledged that the resident should not be in the wheelchair except for meals. The resident was observed on 6/28/06 at 11:10 am, and she was sleeping in the recliner in her room.	F 314	~~Residents are assessed upon admission,~~ quarterly and with significant changes in condition related to skin health and risk for pressure sore development. A plan of care for prevention is developed and implemented based on specific assessed needs. LN staff supervises direct care staff to ensure resident specific preventative measures are implemented consistently at the bedside. **Monitor** The DNS and/or designee will observe at least one resident weekly to ensure that pressure sore prevention measures are implemented consistently at the bedside. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring as deemed appropriate. **Date of Compliance** August 4, 2006	

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F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, it was determined the facility failed to ensure that a resident with a catheter was assessed and evaluated to determine the need for the catheter and appropriate treatment was provided to prevent urinary tract infections. This affected 1 of 2 sampled residents with catheters (#8). Findings include: Resident #8 was admitted to the facility on 4/14/06 and readmitted on 6/21/06 with the diagnoses of coronary artery disease, congestive heart failure, osteoarthritis, osteoporosis, cataracts and depression. The resident's initial MDS, dated 4/21/06, indicated the resident required extensive assistance of one staff for bed mobility, transfers, dressing, toileting, personal hygiene and bathing. A "Bladder Retraining Assessment", dated 6/21/06, documented under catheter "reason for catheter: strict I & O [intake and output] in hospital..." A nursing assessment dated 6/21/06, under bladder documented, "Diagnosis/reason for	F 315	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Aspen Park Rehabilitation & Healthcare does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. **Resident Specific** Resident # 8 discharged from the facility **Other Residents** The ID team reviewed other residents with catheter usage to ensure appropriate documentation to demonstrate clinical necessity and to ensure there were appropriate measures to prevent infections. The plans of care were updated as indicated. Additionally, direct care staff will receive in-service education related to catheter care including placement so as to avoid potential infection risk. Additionally, LN staff will receive in-service education related to appropriate clinical necessity and documentation of such. **Facility Systems** Residents who enter the center with a catheter are immediately assessed for clinical necessity. When indicated, a plan is	

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F 315	Continued From page 44 catheter: may remove when transfer to BSC [bed side commode] easily." The "Admission Orders Record", dated 6/21/06, documented, "Foley catheter...to gravity drainage until able to get to BSC easily. On 6/27/06 at 11:05 am, the Director of Nursing indicated that Resident #8 was admitted with a foley catheter and and it was currently in place to aid in recording intake and output. On 6/27/06 at 6:35 am through 7:35 am, 11:25 am, 11:55 am, and 12:40 pm, resident #8 was observed several times laying in bed with her foley catheter bag with a privacy cover over the bag touching the floor. The bag was hanging off of the side of the bed, but the bed was in a low position. The bottom of the privacy bag was covered in dust and the floor under the resident's bed was visibly dusty. Resident #8 was admitted with a foley catheter and there was no documentation found indicating any medical condition that warranted the continued use of an indwelling catheter. The catheter bag in the privacy cover was observed several times during survey to be in direct contact with the visibly dirty floor.	F 315	~~implemented to remove when not indicated.~~ Additionally, proper care is given to those who require a catheter to prevent potential infections. **Monitor** The DNS and/or designee will review at least one resident weekly related to catheter usage to ensure appropriate indication and infection prevention. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring as deemed appropriate. **Date of Compliance** August 4, 2006	

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F 324 SS=D	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and record review, it was determined the facility did not provide residents with adequate supervision to prevent accidents. This was true for 1 of 12 sample residents (#11) who was observed to be drinking thin liquids when she was to have honey thickened liquids. The findings included: 1. Resident #11 was admitted to the facility on 07/08/05 with diagnoses that included dementia, osteopenia, breast neoplasm and lactose intolerance. The resident's annual MDS signed 6/9/06, documented the resident had short and long term memory loss, was moderately impaired in cognition and decision making, and had mood indicators that were easily altered. Under eating, resident #11 was identified as needing extensive assistance with one person physical assist. Nutritional approaches documented, "mechanically altered diet; therapeutic diet; dietary supplement between meals and on a planned weight change program. Resident #11 was identified as having swallowing problems. The RAP report dated 6/14/06, documented, "Nutritional status." Triggers included: "...mechanically altered diet and therapeutic diet." Under factors that impede ability to consume foods-swallowing problems were triggered.	F 324	~~This Plan of Correction is prepared and~~ submitted as required by law. By submitting this Plan of Correction, Aspen Park Rehabilitation & Healthcare does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. **Resident Specific** The ID team reviewed resident # 11 related to supervision needs related to fluid consumption. The plan of care was updated as indicated. **Other Residents** The ED and DNS rounded in the center to observe for other concerns with supervision. An immediate plan was established for other residents that require modified fluids so as to prevent potential risk. In-service education was provided to nursing staff related to supervision of residents identified to be at risk. The in-service education also included strategies for providing adequate supervision on the SCU in general. This education was provided in part by clinical support staff from the center's parent company.	

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F 324	Continued From page 46 A "Dysphagia Evaluation" was completed on 6/05/06 documenting that resident #11 was a definite risk for: choking, frequently coughing up food during swallow, delayed or slow swallow reflux and wet or gurgly voice quality after swallowing liquids. On 6/06/06 there was a physician's telephone order documenting, "Change diet from mech [mechanical] soft, nectar thick to mech soft, honey thick liquids..." On 6/28/06 at approximately 12:15 pm, resident #11 was observed sitting in the Special Care Unit dining room at the assistance table. She was observed to have a glass of thin liquid appearing to be cranberry juice. Resident #5 was observed to take 3 sips of the thin liquid over a period of approximately 5 minutes and each time she would choke. There were no staff present at the assistance table during this time. On 6/29/06 at approximately 10:00 am, a staff interview was conducted with the Speech Language Pathologist regarding resident #11 drinking thin liquids. She stated, "Resident #11 should definitely be drinking honey thick liquids due to her swallowing difficulties. It would appear that resident #11 took the glass of thin liquid from resident #10 who was sitting to the right of resident #11 at the same table." The facility failed to provide the supervision to prevent resident #11 from taking resident #10's thin liquid. This is a repeat violation from the annual survey	F 324	**Facility Systems** Residents with modified fluids on the SCU are assisted to sit together at the same table. Fluids are served only when a staff member is immediately available to supervise. Additionally, residents are assessed upon admission, quarterly and with significant changes in condition for potential risks. A plan of care is developed and implemented providing direction for supervision and assistive devices to prevent accidents and incidents. **Monitor** The DNS and/or designee will observe residents in the SCU at least weekly to ensure adequate supervision and appropriate assistive devices to prevent accidents and incidents. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring as deemed appropriate. **Date of Compliance** August 4, 2006	

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F 324	Continued From page 47 of 5/13/05.	F 324		
F 329 SS=E	483.25(l)(1) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, it was determined the facility did not ensure that residents receiving medications were adequately assessed, reviewed, monitored and a gradual dose reduction attempted as appropriate. This resulted in a resident receiving the hypnotic medication, Ambien, as a sedative for sleep, for 48 consecutive days. Other residents on psychotropic medications did not have their behavior and sleep monitors completed. This was true for 7 of 9 sampled residents (# 1, 2, 3, 4, 5, 6, & 7). The findings included: 1. Resident #5, a 82 year old female, was admitted to the facility on 11/8/04 with diagnoses that included hypernatremia, Alzheimer, anxiety disorder, arthritis, hypertension, and hypothyroidism.	F 329	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Aspen Park Rehabilitation & Healthcare does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. **Resident Specific** The ID team reviewed resident #'s 1, 2, 3, 4, 5, 6, & 7 related to psychoactive drug usage. Adjustments were made as indicated.	

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F 329	Continued From page 48 The resident's physician telephone orders, dated 12/21/05, documented, "Ambien 5 mg [milligram] [every] HS [night] po [by mouth] / insomnia PRN [as needed]." Review of the resident's medication administration record (MAR) for January 2006, Febuary 2006, March 2006, and May 2006, were reviewed. The resident received Ambien at 5 mg by mouth every night from January 13th thru Febuary 10th for a total of 29 consecutive days, Febuary 12th thru March 31st for a total of 48 consecutive days, and May 5th thru the 22nd for a total of 18 consecutive days. There was no documentation found that alternatives were tried to rule out possible reasons for insomnia prior to the use of the hypnotic medication. The guidance to surveyors instructs that drugs used for sleep induction should only be used if: 1) Evidence exists that other possible reasons for insomnia have been ruled out, 2) Daily use of this drug is less than ten continuous days unless an attempt at a gradual dose reduction is unsuccessful. On 1/16/06 a pharmacy review recommended a gradual dose reduction of the 5 mg of Ambien. The physician disagreed and documented, "PT [patient] to take Ambien earlier in the evening." There was no other explanation for the refusal of the gradual dose reduction. There was no other documentation found that another gradual dose reduction was attempted within the six months. The guidance to surveyors also instruct that drugs used for sleep induction should have a gradual	F 329	**Other Residents** The ID team will review other residents taking psychoactive medications to ensure adequate monitoring to support usage. Any concerns will be addressed and updates made as indicated. In-service education will be provided for nursing staff related to required monitoring behaviors, documentation and required dose reductions. **Facility Systems** Residents are assessed upon admission, quarterly and with significant changes in condition. Residents prescribed psychoactive medications are monitored closely based on assessed target behaviors. The ID team will review behavior monitors at least quarterly to ensure appropriate decisions are made related to on-going drug usage. Residents prescribed hypnotic drugs will have a dose reduction on or before ten consecutive days of usage unless contraindicated and clearly documented as such. **Monitor** The DNS and/or designee will review at least two residents prescribed psychoactive medications weekly to ensure accurate and timely documented monitoring. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of monitoring as deemed appropriate.	

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F 329	Continued From page 49 dose reduction attempted at least three times within six months before one can conclude that a gradual dose reduction is clinically contraindicated. On 6/28/06 at 10:15 am, the DON was interviewed regarding resident #5's Ambien use. She indicated that she could not find any documentation or information showing that the Ambien was given less than ten continuous days on the dates given above or that a gradual dose reduction was attempted and found to be unsuccessful. The DON also indicated that she could not find that other sources for insomnia were looked into prior to starting the Ambien. 2. Resident #3 was admitted to the facility on 3/30/04 with the diagnoses of progressive supranuclear palsy, Parkinson's disease, hypothyroidism and dementia. Review of the resident's "Physician's Orders" for 06/01/06, documented the resident was to be administered Neurontin 100 mg po [by mouth] tid/pain [three times daily]; Zyprexa 2.5 mg [milligrams] po prn [as often as necessary] x [times] one in 24 hrs/oms (organic mental syndrome) with agitated features; and Lexapro 10 mg po qd/depression [every day]. The care plan dated 11/08/04 documented a	F 329	**Date of Compliance** August 4, 2006	

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problem area as, "behavior symptoms r/t [related to] cognitive impairment r/t illness." One of the approaches was documented as, "...administer and monitor effectiveness of psychotropic meds [medications] as ordered. Monitor for side effects/effectiveness and document."

There was a 'Psychotropic Med Review' dated 3/06/06 in the chart. One of the questions stated, "Are targeted behaviors accurate and do they reflect on the behavior sheet?" The written in answer was, "Yes."

Resident #3's Behavior Intervention Monthly Flow Sheet for the months of April, May and June 2006 were reviewed and revealed the following:
*For the month of April the forms listed the following behaviors to monitor, "socially instructive ordering/demanding to others; agitation/fearful affect; depression-irritable, statements, withdrawn." For the area, 'socially instructive ordering/demanding to others' staff failed to complete 15 of the 90 time periods. For the area, 'agitation/fearful affect' staff failed to complete 16 of the 90 time periods. For the area, 'depression-irritable, statements, withdrawn' staff failed to complete 42 of the 90 time periods.
* For the month of May the forms documented the same behaviors to monitor as for April. For the area, 'socially instructive ordering/demanding to others' staff failed to complete 27 of the 93 time periods. For the area, 'agitation/fearful affect' staff failed to complete 41 of the 93 time periods. For the area, 'depression-irritable, statements, withdrawn' staff failed to complete 62 of the 93 time periods.
*For the month of June the forms documented the same behaviors to monitor as for April. For

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the area, 'socially instructive ordering/demanding to others' staff failed to complete 37 of the 81 time periods. For the area, 'agitation/fearful affect' staff failed to complete 27 of the 81 time periods. For the area, 'depression-irritable, statements, withdrawn' staff failed to complete 39 of the 81 time periods.

On 6/28/06 at approximately 10:00 am, a staff interview was conducted with the charge nurse on the Special Care Unit regarding completion of the behavior and sleep monitors. She stated, "The facility conducted inservices on the completion of the behavior and sleep monitors. It has been an area of focus. Appears that we haven't done a very good job with completing them."

The facility failed to accurately document resident #3's behaviors on the 'Behavior/Intervention Monthly Flow Record' in order to accurately communicate with the physician to facilitate appropriate medications and dosages and interventions for the resident.

3. Resident #1 was admitted to the facility on 10/26/05 with the diagnoses of Alzheimer's disease, breast neoplasm, osteoporosis and esophageal reflux disorder.

Review of the resident's "Physician's Orders" for 06/01/06, documented the resident was to be administered Klonopin, 0.5 mg [milligrams] po [by mouth] bid [twice per day] (anxiety disorder); Remeron 1.5 mg, 1 po qhs [every night] (depression); and Ultram 50 mg, 1-2 tabs [tablets] q6h [every 6 hours] prn (pain).

The care plan dated 11/08/04 documented a

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F 329	Continued From page 52 problem area as, "behavior symptoms r/t [related to] cognitive impairment." One of the approaches was documented as, "...administer and monitor effectiveness of psychotropic meds [medications] as ordered. Monitor for side effects/effectiveness and document." There was a 'Psychotropic Med Review' dated 3/30/06 in the chart. One of the questions stated, "Are targeted behaviors accurate and do they reflect on the behavior sheet?" The written in answer was, "Yes." Resident #1's Behavior Intervention Monthly Flow Sheet for the months of April, May and June 2006 were reviewed and revealed the following: *For the month of April the forms listed the following behaviors to monitor, "agitation-r/t paranoia or delusions; depression-sad or tearful affect." For the area, 'agitation-r/t paranoia or delusions' staff failed to complete 22 of the 90 time periods. For the area, 'depression-sad or tearful affect' staff failed to complete 24 of the 90 time periods. * For the month of May the forms documented the same behaviors to monitor as for April. For the area, 'agitation-r/t paranoia or delusion' staff failed to complete 44 of the 93 time periods. For the area, 'depression-sad or tearful affect' staff failed to complete 44 of the 93 time periods. *For the month of June the forms documented the same behaviors to monitor as for April. For the area, 'agitation-r/t paranoia to delusions' staff failed to complete 31 of the 93 time periods. For the area, 'depression-sad or tearful affect' staff failed to complete 29 of the 81 time periods. Resident #1's 'Sleep Monitor' for the months of	F 329		

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F 329	Continued From page 53 April, May and June 2006 were reviewed and revealed the following: *For the month of April there were no days that were totally completed. April 4, 6, 12, 13, 14, 19, 20 and 21 were blank with no time periods completed; April 1st and 7th had 4 one-half hour time periods completed of the 47 available; April 15 had 10 one-half hour time periods completed of the 47 available; April 2, 3, 11 and 18 had 13 one-half hour time periods completed of the 47 available; April 5th had 14 one-half hour time periods completed of the 47 available; April 8, 9, 10, 16 and 17 had 17 one-half hour time periods completed of the 47 available; April 27th had 20 one-half hour time periods completed of the 47 available; April 21st had 24 one-half hour time periods completed of the 47 available; April 23, 24, 29 and 30th had 27 one-half hour time periods completed of the 47 available; April 26th had 30 one-half hour time periods completed of the 47 available; April 28th had 32 one-half hour time periods completed of the 47 available; and April 25th had 34 one-half hour time periods completed of the 47 available. *For the month of May there were no days that were totally completed. May 2, 10, 11, 12, 13, 18, 19, 23 and 24 were blank with no time periods completed; May 3, 6 and 26 had 4 one-half hour time periods completed of the 47 available; May 9, 14, 15, 17, 20, 22 and 31 had 13 one-half hour time periods completed of the 47 available; May 21 had 14 one-half hour time periods completed of the 47 available; May 5, 7, 8, 16, 25, 27, 28, 29 and 30 all had 17 one-half hour time periods completed of the 47 available; May 1st had 45 one-half hour time periods completed of the 47 available. *For the month of June there were no days that	F 329		

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F 329	Continued From page 54 were totally completed. June 1, 2 and 9 were blank with no time periods completed; June 8th had 3 one-half hour time periods completed of the 47 available; June 15, 22, 25, and 27 had 13 one-half hour time periods completed of the 47 available; June 6, 14, 18, 19, 20, 21 and 26 all had 17 one-half hour time periods completed of the 47 available; June 3rd had 18 one-half hour time periods completed of the 47 available; June 12th had 19 one-half hour time periods completed of the 47 available; June 5th had 20 of the one-half hour time periods completed of the 47 available; June 13th had 22 one-half hour time periods completed of the 47 available; June 7 and 11 had 26 one-half hour time periods completed of the 47 available; June 23rd had 27 one-half hour time periods completed of the 47 available; June 4th had 28 one-half hour time periods completed of the 47 available; June 24th had 39 one-half hour time periods completed of the 47 available; June 10, 16 and 17 had 40 one-half hour time periods completed of the 47 available. On 6/28/06 at approximately 10:00 am, a staff interview was conducted with the charge nurse on the Special Care Unit regarding completion of the behavior and sleep monitors. She stated, "The facility conducted inservices on the completion of the behavior and sleep monitors. It has been an area of focus. Appears that we haven't done a very good job with completing them." The facility failed to accurately document resident #1's behaviors on the 'Behavior/Intervention Monthly Flow Record' and 'Sleep Monitor' in order to accurately communicate with the physician to facilitate appropriate medications and dosages and interventions for the resident.	F 329		

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4. Resident #7 was admitted to the facility on 1/17/05 with the diagnoses of schizoaffective disorder, Alzheimer's disease, Parkinson's, dysphagia and depression.

Review of the resident's Physician's Orders for 06/01/06 documented the resident was to be administered Zyprexa 2.5 mg [milligrams] po hs [at night] (schizoaffective disorder).

The care plan dated 2/02/05 documented a problem area as, "Trauma, potential for r/t seizure disorder r/t psychoactive drugs r/t disease process dementia..." One of the approaches was documented as, "...administer and monitor effectiveness of psychotropic meds [medications] as ordered. Monitor for side effects/effectiveness and document."

There was a 'Psychotropic Med Review' dated 3/06/06 in the chart. One of the questions stated, "Are targeted behaviors accurate and do they reflect on the behavior sheet?" The written in answer was, "Yes."

Resident #7's 'Behavior Intervention Monthly Flow Sheet' for the months of April, May and June 2006 were reviewed and revealed the following:
*For the month of April the forms listed the following behaviors to monitor, "calling-out, vocalization; self-abuse scratching self." For the area, 'calling-out, vocalization' staff failed to complete 21 of the 90 time periods. For the area, 'self-abuse scratching self' staff failed to complete 21 of the 90 time periods.
* For the month of May the forms documented the same behaviors to monitor as for April. For the

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area, 'calling-out, vocalization' staff failed to complete 40 of the 93 time periods. For the area, 'self-abuse scratching self' staff failed to complete 41 of the 93 time periods.
*For the month of June the forms documented the same behaviors to monitor as for April. For the area, 'calling-out, vocalization' staff failed to complete 27 of the 81 time periods. For the area, 'self-abuse scratching self' staff failed to complete 30 of the 81 time periods.

On 6/28/06 at approximately 10:00 am, a staff interview was conducted with the charge nurse on the Special Care Unit regarding completion of the behavior and sleep monitors. She stated, "The facility conducted inservices on the completion of the behavior and sleep monitors. It has been an area of focus. Appears that we haven't done a very good job with completing them."

The facility failed to accurately document resident #7's behaviors on the 'Behavior/Intervention Monthly Flow Record' in order to accurately communicate with the physician to facilitate appropriate medications and dosages and interventions for the resident.

5. Resident #6 was admitted to the facility on 7/13/04 with diagnoses of demential, auditory hallucinations and congestive heart failure.

The recapitulated physician's orders for the month of June 2006, indicated the resident received Zyprexa, 2.5 milligrams twice a day for dementia with psychotic features.

The mental health note dated 5/18/06, stated, "Patient is seen as a follow up from 3/23. At that

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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time he discontinued her routine Zyprexa and put her on PRN [as needed]. We received a call from staff on 4/14 indicating an increase in her agitation and fearfulness. At that time an order was given to restart her Zyprexa at 2.5 mg [milligrams] q [every] am and to continue the PRN x [times] one in 24 hours. Apparently there was some continued agitation with paranoia and [name of MD] increased her Zyprexa on 5/1 to 2.5 mg b.i.d. [twice a day]. She is continuing to have some difficulties with her wanting to go home and difficult to redirect. She at times does not engage in activities or has to be encouraged to eat because she thinks she is leaving momentarily. She does sleep well at night...Impression: Dementia not otherwise specified with history of paranoia and psychosis. These symptoms were fairly stable but have returned over the past month and again are stabilizing with the reinstitution of regular doses of Zyprexa. I would recommend this patient remain on Zyprexa 2.5 mg b.i.d. at this time and will see her again in one month and if behaviors are stabilized can perhaps try a reduction at that time."

The monthly behavior/intervention records for March thru June of 2006, indicated there were several days with no documentation. The following was revealed:

a. The March of 2006 behavior/intervention record listed agitation related to delusions, irritability and restlessness as behaviors to be monitored.

The day shift documented on 7 out of the 31 days in March of 2006. On those 7 days, there were no behaviors which was indicated with a "0." The

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F 329	Continued From page 58 documentation occurred on 3/20, 3/21, 3/22, 3/23, 3/28, 3/29, and 3/30. The evening shift documented on 16 of the 31 days in March of 2006. The documentation indicated there were no behaviors. The documentation occurred on 3/01, 3/02, 3/03, 3/06, 3/07, 3/08, 3/10, 3/13, 3/14, 3/15, 3/16, 3/20, 3/21, 3/22, 3/23, and 3/28. The night shift documented on 13 of the 31 days in March of 2006. The documentation indicated there were no behaviors. The documentation occurred on 3/01 - 3/09, 3/21, 3/22, 3/27, and 3/29. A tool, frequently used by mental health practitioners to determine proper dosage of antipsychotic medications or appropriate interventions, was an objective and quantitative monitoring of behaviors. Incomplete behavior records were not a useful tool and do not give practitioners an accurate picture of the resident's response to medications or interventions. This resident began a dose reduction of an antipsychotic medication on 3/23/06. b. The April 2006 behavior/intervention record listed 2 sections of behaviors. Section #1 listed the behavior of agitation with irritability, restlessness and multiple complaint. The interventions were to redirect, 1 to 1, refer to nurse's notes, activity, return to room, give food, give fluids, change environment, and change activity. Section #2 listed the behaviors of delusions/hallucinations. The interventions were to redirect, activity, return to room, give food, give fluids, re-orient, change environment, and change	F 329		

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F 329	Continued From page 59 activity. The day shift documented on 20 of the 30 days in April of 2006 for the section #1 behaviors. On 4/14/06 and 4/27/06 the resident was having behaviors. On 4/14/06, the documentation indicated that all interventions were tried with success. On 4/27/06, the documentation indicated that the interventions were to change the environment and change the activity. The documentation indicated the interventions were not successful. The day shift documented on 22 of the 30 days in April of 2006 for the section #2 behaviors. The documentation indicated the resident had behaviors on 5 days. On 4/11/06 the record stated, "x 2 [2 times]." There were no interventions documented. On 4/16/06, the documentation indicated there was 1 instance of behaviors. The interventions were to redirect and 1 on 1. The outcome was unchanged. There were "+" symbols entered into 4/18, 4/19, and 4/27. There was no documentation of interventions being tried. The evening shift documented on 13 of the 30 days in April of 2006 for the section #1 behaviors. On the 13 evenings where documentation was done, there were no behaviors. The evening shift documented on 11 of the 30 days in April of 2006 for the section #2 behaviors. On the 11 evenings where documentation was done, there were no behaviors except for 4/16/06. According to the documentation, the interventions used by the staff were successful.	F 329		

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F 329	Continued From page 60 The night shift documented on 20 of the 30 days in April of 2006 for both the section #1 and #2 behaviors. According to the documentation, there were no behaviors on those days. c. A sleep monitor was maintained for the month of April of 2006. The sleep monitor indicated that for 17 of the 30 days in April, there was no documentation. On 4/02, 4/23, and 4/26, the only documentation was completed from 10:00 pm to 11:30 pm. The sleep monitor indicated the resident was asleep during those hours. Only 4 days had documentation of awake/sleep times and on those days, the sleep monitor was not maintained for the entire day. On 4/08, the sleep monitor indicated the resident was awake from 6:00 pm to 8:30 pm and asleep from 9:00 pm to 11:30 pm. There was no documentation for the rest of the day. The sleep monitor was similar for 4/09, 4/16, and 4/17. d. The May 2006 behavior/intervention record was similar to the previous months with lapses in documentation. The day shift did not document behaviors listed in the section #1(agitation, irritability, restless and wandering) for 6 of the 31 days in May of 2006. In the section #2 list of behaviors (delusions and hallucinations), the day shift did not document behaviors for 7 of the 31 days. During the month of May, the record indicated the resident exhibited behaviors on the day shift on 5/08 and 5/09. On 5/08 the record indicated the resident had delusions and hallucinations. On 5/09 the record indicated the resident had all behaviors listed in section #1 and #2.	F 329		

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F 329	Continued From page 61 The evening shift did not document behaviors listed in section #1 for 12 of the 31 days in May of 2006. The evening shift did not document behaviors listed in section #2 for 10 of the 31 days in May of 2006. The record indicated the resident had delusions and hallucinations on 5/10/06 and staff attempted to redirect and do 1 to 1. The outcome of the interventions was not documented. The night shift did not document behaviors listed in sections #1 and #2 for 13 of the 31 days in May of 2006. The record indicated the resident had all listed behaviors on 5/01/06 at least 3 times. Interventions such as redirection, 1 to 1 and reorientation were attempted by the staff but the outcome was not documented. e. The sleep monitor for May of 2006 had no documentation for 5 of the 31 days in May. The sleep monitor had no documentation of awake time and on 17 days, the documentation began at 10:00 pm. On the remaining days of documentation, the sleep monitor was started at either 10:30 pm or 12:00 pm. The sleep monitor failed to show an accurate awake/sleep cycle. f. The June behavior/intervention monitor from 6/01/06 to 6/28/06 also had several lapses in documentation. The day shift failed to document agitation, wandering or restless behaviors on 10 of 28 days in June of 2006. The day shift failed to document delusions or hallucinations for 12 of 28 days in June of 2006.	F 329		

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F 329	Continued From page 62 The evening shift failed to document all behaviors listed for 16 of the days. The night shift's also failed to document behaviors for 7 days. On 6/28/06 at 2:20 pm, the DON was interviewed concerning the gaps in the sleep and behavior records. The DON stated, "this has been an ongoing problem with both the nurses and the CNAs, they have been inserviced over several months." The DON explained that the problem had been identified several months earlier and the facility had made it a PI project. According to the DON, part of the PI project was to have both the CNAs and the nurses do the behavior and sleep monitoring. The DON stated, "it's still a problem." The DON continued to explain that the social worker collected behavior and sleep documentation from the CNAs and the nurses and tried to compile the data and "come up with the best information possible." The DON acknowledged that neither the CNAs nor the nurses did good documentation on the behavior and sleep monitors. 6. There were similar findings with the behavior/intervention and sleep monitoring records for residents #4 and #2. This is a repeat deficiency from the annual survey of 5/13/05.	F 329		

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F 369 SS=D	483.35(g) DIETARY SERVICES - ASSISTIVE DEVICES The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on meal observation, record review, and staff interview it was determined the facility did not assess residents to ensure that special eating equipment and utensils were provided to resident #10. This had the potential to effect 1 of 1 sampled residents (#10) and all other residents who required special eating equipment and utensils in the facility. The findings include: Resident #10 was admitted to the facility on 10/01/99, with diagnoses of cerebral atherosclerosis and atrial fibrillation. Resident #10's quarterly assessment MDS, dated 5/31/06, indicated that she was severely cognitively impaired and required limited assistance of one person with eating. Resident #10's care plan, dated 1/18/05, documented under problem, "Nutrition Risk: Potential/Actual. R/t [related to] variable intake r/t disease process (specify) impaired vision r/t cataract left eye." The goal for this problem area was, "Will consume 75% of meals." One of the approaches was, "To eat in SCU [special care unit] dining room at all meals at assisted table." On 6/27/06 at 8:20 am, resident #10 was observed to be eating her breakfast meal in the Special Care Unit at the assisted table. She had her food on a regular plate and was using her fingers to eat foods that she could pick up and	F 369	~~This Plan of Correction is prepared and~~ submitted as required by law. By submitting this Plan of Correction, Aspen Park Rehabilitation & Healthcare does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. **Resident Specific** The ID team reviewed resident # 10 related to use of special equipment during meals. Adjustments were made as indicated to the plan of care. **Other Residents** The ID team will observe other residents during meal service to ensure appropriate adaptive equipment is provided. Additionally, in-service education will be provided to direct care staff regarding meal service and providing adequate assistance and assistive devices. When indicated, referrals will be made to therapy for specialized services. The plans of care will be updated as indicated.	

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F 369	Continued From page 64 eat. Resident #10 did not attempt to use her spoon or fork to eat with. The resident ate approximately 25% of her meal. No staff assistance was offered to the resident during the observation. On 6/27/06 from 12:30 to 1:00 pm, resident #10 was observed during the lunch meal. Resident #10 used her fingers to eat those items that she could easily pick up and eat. She did pick up her spoon and used it to move some food around on her plate. She did not attempt to use the spoon or fork to eat any food. The resident ate approximately 25% of her meal. No staff assistance was offered to the resident during the observation. On 6/28/06 at the breakfast meal resident #10 was again observed and similar results were found as those on 6/27/06. On 6/28/06 at approximately 1:30 pm a staff interview was conducted with the charge nurse on the Special Care Unit regarding resident #10's eating. The charge nurse reported that resident #10 could become quite resistant to any staff interventions whether it be cueing or to encourage her to use her fork and spoon to eat. The surveyor inquired whether resident #10 had been referred to speech or occupational therapy for evaluation of her eating and the Charge Nurse said that she had not. She stated that referrals are made to specialists when staff identified a problem such as weight loss or if the resident was having difficulty eating. On 6/29/06 at approximately 11:00 am, an interview with the Occupational Therapy	F 369	**Facility Systems** Residents are assessed upon admission, at least quarterly and with any significant change of condition related to self-performance of activities of daily living. When indicated, assistive devices are provided for meal service. On-going concerns are referred to therapy services when indicated. **Monitor** The DNS and/or designee will observe at least one meal weekly to ensure residents requiring assistive devices have them available and are assisted to use them as necessary. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of monitoring as deemed appropriate. **Date of Compliance** August 4, 2006	

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F 369	Continued From page 65 department revealed that they had not received a referral to assess resident #10 during meals. The surveyor requested that the Occupational Therapy department conduct a screening assessment of resident #10. On 6/29/06 an Occupational Therapy Screen was conducted for resident #10. The report stated, "Screening completed by OT [Occupational Therapy] and this resident may benefit from skilled services for self-dining skills at this time...The following observations may indicate a need for OT [occupational therapy] referral at this time: 1. no longer able to ID/attend [identify] to utensils most of the time, even when utensils are vividly colored (previous adaptation); 2. increased cueing required from caregivers (increased burden of care); 3. may benefit from re-training, with much repetition, in use of adapted spoon or adapt meal choices for finger foods/fork use only; 4. adapt fork and spoon to encourage appropriate grip without cueing." The report went on to state, "Caregivers have appropriately adapted rsdt [resident] care when symptoms of progressive dementia affect functional status, but skilled OT may further supplement/alter care to minimize caregiver burden and maximize resident #10's independence at meal time." The facility did not assess residents to ensure that special eating equipment and utensils were provided to resident #10 to ensure that she was functioning at her highest level as independently as possible.	F 369		

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F 371 SS=F	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility did not ensure sanitary conditions were maintained in the following area: 1) possibly contaminated gloves/sugar packets in direct contact with ready-to-eat food. This had the potential to affect 100 % of the residents who ate in the facility including 12 of 12 sampled residents (#1-12). Findings include: 1. a. On 6/28/06 at 2:00 pm, during an observation of food preparation, a kitchen staff member was observed to get out a large bag of lettuce and salad dressing to make a salad. The kitchen staff member with her gloved hands cut open the bag of lettuce with visibly dirty scissors and then dumped the bag of lettuce into a large bowl with dressing. The kitchen staff member then with the same possibly contaminated gloved hands mixed the salad with the dressing with her gloved hands. Chapter 3, subsection 304.15 (A) of the 2005 Federal Food Code indicates, "If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation."	F 371	~~This Plan of Correction is prepared and~~ submitted as required by law. By submitting this Plan of Correction, Aspen Park Rehabilitation & Healthcare does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. **Resident Specific** No outcomes for resident #'s 1-12 related to food contamination were observed. **Other Residents** The ED rounded in the kitchen with the food services manager to ensure sanitary conditions. In-service education will be provided to kitchen staff related to sanitation - specifically addressing handling food with gloved hands and sanitized scissors. Additionally, direct care staff will receive in-service education related to observing for sanitary foodservice at the table and when necessary, replacement of the food items. **Facility Systems** Kitchen staff receives training with orientation on kitchen sanitation standards including proper food preparation and	

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F 371	Continued From page 67 b. On 6/28/06 at approximately 8:00 am, a staff person was observed to deliver a breakfast tray to resident #5. The staff person was observed to tear open two self serve packages of granulated sugar and pour them on resident #5's hot cereal. When the staff person moved her hand away from the resident's bowl of hot cereal she was observed to drop one of the empty packages of granulated sugar in the resident's bowl of cereal. The resident was sitting at the table with her eyes closed and was not aware of the empty package in her bowl of cereal. On 6/28/06 at approximately 8:15 am, a different staff person was observed placing clean gloves on her hands and removing the empty sugar packet from resident #5's bowl of cereal. After having removed the package, the staff person removed her gloves and washed her hands. The staff person did not replace the contaminated bowl of cereal. She then returned to resident #5's table. Resident #5 was still sitting at the table with her eyes closed and had not engaged in eating her breakfast. The staff person was observed to speak resident #5's name at which time resident #5 became alert and began eating breakfast. Chapter 3, subsection 701.11 (D) of the 2005 Federal Food Code indicates, "Food that is contaminated by food employees, consumers, or other persons through contact with their hands, bodily discharges, such as nasal or oral discharges, or other means shall be discarded." This is a repeat violation from the annual survey of 5/13/05.	F 371	handling. Direct care staff also receives training on hire related to meal service and this will include ensuring that food served is sanitary or replaced. **Monitor** The ED and/or designee will round in the kitchen and make observations weekly as well as observe meal service on the units to ensure food is handled and served following sanitary standards. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring as deemed appropriate. **Date of Compliance** August 4, 2006	

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F 441 SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility did not ensure each resident was offered the pneumoccocal vaccination and if a resident refused the vaccination, they were educated on the potential risks of not getting the vaccination. This was true for 4 of 12 sampled residents (#'s 1, 4, 8 and 9) Findings include: 1. Resident #8 was admitted to the facility on 4/14/06 and readmitted on 6/21/06 with the diagnoses of coronary artery disease, congestive heart failure, osteoarthritis, osteoporosis, cataracts and depression. On 6/28/06 at 2:55 pm, the DON and facility administrator were asked to provide the documentation that residents #1, 4, 8, and 9 were offered the pneumoccocal vaccination. The DON indicated she would look into the matter. On 6/29/06 at 9:00 am, the DON indicated she did not have documentation at the facility on	F 441	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Aspen Park Rehabilitation & Healthcare does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. **Resident Specific** Resident # 8 discharged from the facility. The ID team reviewed resident #'s 1, 4, & 9 related to Pneumococcal vaccination. These residents received the vaccine. The residents and/or significant others were informed of the risks and benefits. Documentation was provided in their respective records. **Other Residents** The ID team reviewed other residents that had not received the vaccine. The vaccine was offered again with risks and benefits discussed as indicated. Documentation of this is available in the medical records. Additionally, LN staff will receive in-service education regarding Pneumococcal vaccination including required documentation.	

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F 441	Continued From page 69 resident #8's pneumoccocal vaccination but would keep looking for it. This documentation was not provided as of 7/5/06. 2. Resident #1 was admitted to the facility on 10/26/05 with the diagnoses of alzheimer's, breast neoplasm, osteoporosis and esophageal reflux disorder. On 6/28/06 at 2:55 pm, the DON and facility administrator were asked to provide the documentation that resident #1, 4, 8, and 9 were offered the pneumoccocal vaccination. The DON indicated she would look into the matter. On 6/29/06 at 9:00 am, the DON indicated she did not have documentation at the facility on resident #1's pneumoccocal vaccination but would keep looking for it. This documentation was not provided as of 7/5/06. 3. Similar findings for residents #4 and #9.	F 441	**Facility Systems** The Pneumococcal vaccine is offered to residents upon admission unless otherwise indicated. Risks and benefits are relayed to the resident/family as required. Refusals are documented in the medical records as indicated. **Monitor** The DNS and/or designee will review two residents weekly to ensure appropriate action with regard to vaccinations. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring as deemed appropriate. **Date of Compliance** August 4, 2006	
F 445 SS=D	483.65(c) INFECTION CONTROL - LINENS Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations it was determined the facility did not ensure that linens were properly stored. This affected 1 of 3 linen rooms. The findings include:	F 445	The facility strongly disagrees with this deficiency as cited. Sheets are not stored on the floor. This white sheet mentioned in the statement of deficiency had obviously fallen to the floor and when picked-up was placed in the bin for laundering and not given to a resident for use. Not withstanding the aforementioned, the following POC is being implemented. **Resident Specific** No resident received a soiled sheet. The white sheet was removed and placed in the bin for laundering and the floor cleaned.	

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	135093	A. BUILDING _____ B. WING _____	06/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 445	Continued From page 70 On 6/28/06 at 11:10 am and at approximately 3:30 pm. the linen room located on the 200 hall, near the central nurses station, was observed to have a folded, white sheet, stored on the floor, under the dedicated shelving for the linens. The floor, under the shelving, was covered with dust. The folded sheet was lifted and it was observed to be covered with dirt and dust. At the end of the day meeting with the administrator and DON on 6/29/06 at approximately 1:45 pm, they were told of the dirty floor and the sheet stored on the floor.	F 445	**Other Residents** The ED and DNS rounded in the center to ensure other linen was properly stored. Direct care staff will receive in-service education regarding linen storage. **Facility Systems** Linen is laundered and stored on the designated shelving in closets for each hall. If linen falls to the floor, it is removed and sent back for laundering. House keeping staff will include linen closets during daily cleaning so as to ensure floors are kept reasonably free of dust. **Monitor** The ED will round at least weekly and observe linen closets to ensure clean and properly stored linen. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring as deemed appropriate. **Date of Compliance** August 4, 2006 This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Aspen Park Rehabilitation & Healthcare does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal	
F 456 SS=F	483.70(c)(2) SPACE AND EQUIPMENT The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined the facility did not ensure that 2 of 2 clothes dryers in the laundry room had been cleaned of lint per the manufacture's recommendations. The findings include: According to the National Fire Protection Association's (NFPA), "Causes of Fires and Direct Property Damage Structure Fires in Facilities that Care for the Aged, 1994 - 1998," 20.3% percent of the fires in nursing homes started in the dryer. The NFPA noted that dryer lint was highly combustible and recommended that dryer lint filters be cleaned after each use,	F 456		

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F 456	Continued From page 71 that special attention be given to removing accumulated lint from around the drum and that the exhaust hood, transition hose and metal ducts should also be inspected and cleaned on a regular basis. On 6/29/06 at 9:10 am, the two 75 pound dryers in the laundry room were observed to have a large accumulation of lint in the bottom lint compartment area. The manufacturers recommendations on both dryer compartment doors, stated, "Lint compartment Must Be Cleaned Daily." The compartment area was approximately 36 inches by 36 inches and 3 feet deep. Inside both compartments, the lint screens were full of lint and lint was accumulated on the floor, sides and top portions of the compartments. The maintenance man, swept out one compartment. The pile of lint was approximately 10 inches by 10 inches and 2 inches deep. A laundry worker stated, "we're short of help, it didn't get cleaned yesterday." The surveyor closely inspected a lint compartment and noticed the top portion where the electrical for the high temperature limit switch and the dryer tumbler was visible and entirely covered with lint. When the surveyor scraped off some of the lint, the laundry worker stated, "I've never seen that much lint before." The surveyor checked the second dryer and found the same problem with the top section of that lint compartment, including the electrical for the limit switch and the exposed tumbler to be covered with lint. The maintenance man stated, "I think I better change my cleaning routine to include using the vacuum to get this [meaning the top	F 456	proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. **Resident Specific** No residents were mentioned in the statement of deficiency. **Other Residents** As noted, the dryers were immediately cleared of excess lint. Laundry staff received in-service training on the requirements to clean the dryers daily and more often if needed. **Facility Systems** The dryers will be cleaned daily and excess lint removed. Laundry staff will inspect the dryers with each usage and clean as needed before used. **Monitor** The ED and/or designee will round in the laundry room weekly to ensure dryers are maintained clean and free of lint as indicated. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring as deemed appropriate. **Date of Compliance** August 4, 2006	

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F 456	Continued From page 72 portion of the compartment].	F 456	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Aspen Park Rehabilitation & Healthcare does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
F 458 SS=B	483.70(d)(1)(ii) RESIDENT ROOMS Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and room measurements, it was determined the facility failed to ensure that all multiple resident rooms contained 80 square feet per resident. This was true for 4 resident rooms on the 200 hall (#202, 204, 206 & 208). The findings include: Observations of rooms 202, 204, 206, and 208 on the evening of 6/26/06 at approximately 6:00 pm, indicated the facility maintained a license for 94 beds. The above mentioned rooms were licensed/certified for two residents. Each of the rooms measured 158.8 square feet. This did not meet the required 80 square feet per resident or 160 square feet in a 2-resident room. The rooms require a waiver. A interview with the ADM on 6/29/06 at approximately 1:45 pm, indicated the facility was familiar with this repeat deficiency and was aware of the need to request a waiver. This is a repeat violation from the annual survey of 5/13/05.	F 458	**Resident Specific** Resident rooms 202, 204, 206, & 208 are certified for two residents, but set-up for only one resident. Only one resident resides in each of these rooms and it is not anticipated that this will change. A waiver was requested prior to exit of the surveyors. **Other Residents** Other resident rooms were observed and meet the minimum standards for space. **Facility System** These rooms (202, 204, 206, & 208) are set-up and used for private rooms and have been for at least 7 years. The center has requested a waiver. **Monitor** The ED will ensure the waiver is received and include it in the center's records. **Date of Compliance** August 4, 2006	

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F 502 SS=D	483.75(j)(1) LABORATORY SERVICES The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, it was determined the facility did not ensure laboratory services were ordered in a timely manner. This was true for 1 of 12 sampled residents (# 8). Findings include: Resident #8 was admitted to the facility on 4/14/06 and readmitted on 6/21/06 with the diagnoses of coronary artery disease, congestive heart failure, osteoarthritis, osteoporosis, cataracts and depression. Resident #8's physician orders dated 06/23/06 documented, "UA [urinalysis], C & S [culture and sensitivity] via Foley." On 6/26/06, resident #8's medical record was reviewed and no urinalysis or culture and sensitivity was found in the resident's record. This was 3 days after the physician orders were received. The DON was made aware of this on 6/27/06 at 11:05 am by the surveyor. The DON at this time indicated that she would get the lab work done that same day. On 6/28/06 the DON provided the lab report to the surveyor.	F 502	**Resident Specific** Resident # 8 discharged from the center. **Other Residents** The DNS reviewed other residents for timely lab tests. Corrections were made as indicated. LN Staff will received in-service education related to processing lab orders to ensure timely completion. **Facility Systems** The LN that takes an order for a lab test will complete the order and ensure that the lab test is properly ordered and placed on the calendar if not immediate. If immediate, the lab will be drawn and sent immediately to the lab for processing. **Monitor** The DNS and/or designee will review other residents for timely lab testing. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring as deemed appropriate. **Date of Compliance** August 4, 2006	

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F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review it was determined that the facility did not ensure clinical records for 2 of 12 sampled residents (#1 and 5) were complete and accurately documented. Findings include: 1. Resident #1 was admitted to the facility on 10/26/05 with diagnoses of Alzheimer's disease, breast neoplasm, osteoporosis and esophageal reflux disorder. The care plan dated 10/27/05 identified a problem area as, 'routine care needs'. One of the approaches for this problem area stated, "monitor and record % of all meals. Offer replacement if rsdt [resident] eats 50% or less. Record % of replacement." On 6/27/06 resident #1 was observed during the breakfast meal and she consumed approximately 25% of the meal. Review of the meal monitor for 6/27/06 breakfast meal revealed that staff	F 514	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Aspen Park Rehabilitation & Healthcare does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. **Resident Specific** The ID team reviewed resident #'s 1 & 5 related to meal intake and accuracy of meal monitoring. Direct care staff were counseled related to accuracy of the meal monitor records and offering of meal replacement. **Other Residents** The DNS rounded and observed other meal monitor records including accuracy. No other concerns were observed. Direct care staff will receive in-service education related to accuracy in meal monitor recording and offering of meal replacement. **Facility Systems**	

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F 514	Continued From page 75 recorded she had consumed 100% of the meal. On 6/27/06 resident #1 was observed during the lunch meal and she consumed approximately 25% of the meal. Review of the meal monitor for 6/27/06 lunch meal revealed that staff recorded she had consumed 75% of the meal. On 6/29/06 at approximately 10:15 am, a staff interview was conducted with the DNS regarding the completion of the resident's meal monitors. She stated that CNAs completed the meal monitors. She stated, "the CNAs are trained on how to complete the meal monitors in the CNA class." The facility educational coordinator also provided some instructions on how to complete them. The surveyor asked if the facility had any means of verifying the accuracy of the information that the CNAs entered on the meal monitors. The DNS stated that at this time that was not something that was reviewed. The facility failed to accurately record the % of meals that resident #1 ate on 6/27/06 for the breakfast and lunch meals on the Special Care Unit. 2. Resident #5 was admitted to the facility on 11/8/04 with the diagnoses of hypernatremia, Alzheimer's, arthritis, hypertension, and hypothyroidism. The care plan dated 3/30/06 under problem (9) nutrition risk, under approach number (4), documented, "monitor and record % [percentage] of all meals. Offer replacement if resident eats 50% or less (record % of replacement)".	F 514	Direct care staff receives training upon hire on meal intake monitoring and accuracy in recording. This training is repeated as indicated. Direct care staff observe for meal intake and accurately record the intake in the records and offering of meal replacement as indicated. Concerns are reported to LN staff for further follow-up. LN staff spot check for accuracy as part of supervisory duties. **Monitor** The DNS and/or designee will review meal monitors for at least two residents weekly to ensure completeness and accuracy. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring as deemed appropriate. **Date of Compliance** August 4, 2006	

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F 514	Continued From page 76 On 6/27/06 resident #5 was observed in the special care unit during the breakfast meal and she consumed approximately 40% of the meal. Review of the meal monitor for 6/27/06 breakfast meal revealed that staff recorded she had consumed 25% of the meal. On 6/28/06 resident #5 was observed in the special care unit during the breakfast meal and she consumed approximately 10% of the meal. Review of the meal monitor for 6/27/06 lunch meal revealed that staff recorded she had refused the meal. On 6/28/06 at approximately 11:40 am, the DON was interviewed on the training of the meal monitoring. She indicated that she was not sure who trained the LN or CNAs to monitor and record the meals and that she would look into it. At 1:00 pm, the DON indicated that the CNAs received training when they completed their CNA class. This is a repeat violation from the annual survey of 5/13/05.	F 514		

Bureau of Facility Standards

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C 000	INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the annual State licensure survey of your facility. The surveyors conducting the survey were: Lory Dayley, RD, Team Coordinator Diane Miller, LCSW Barb Franek, RN, COHN-S Survey Definitions: MDS = Minimum Data Set assessment RAI = Resident Assessment Instrument RAP = Resident Assessment Protocol DON = Director of Nursing LN = Licensed Nurse RN = Registered Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record	C 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Aspen Park Rehabilitation & Healthcare does not admit that the deficiencies listed on the State Form exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. RECEIVED JUL 26 2006 FACILITY STANDARDS	
C 121	02.100,03,c,v v. Is encouraged and assisted, throughout his period of stay, to exercise his rights as a patient/resident and as a citizen, and to this end may voice grievances and recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;	C 121	Refer to the Plan of Correction for F 166	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: ED

(X6) DATE: 7/25/06

Bureau of Facility Standards

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C 121	Continued From page 1 This Rule is not met as evidenced by: Refer to F166 as it related to the grievances.	C 121	Refer to the Plan of Correction for F 241	
C 125	02.100,03,c,ix ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Refer to F241 as it related to dignity issues.	C 125		
C 147	02.100,05,g g. Chemical restraints shall not be used as punishment, for convenience of the staff, or in quantities that interfere with the ongoing normal functions of the patient/resident. They shall be used only to the extent necessary for professionally accepted patient care management and must be ordered in writing by the attending physician. This Rule is not met as evidenced by: Refer to F147 as it related to incomplete monitoring logs and hypnotics used for more then 10 consecutive days.	C 147	Refer to the Plan of Correction for F 329	
C 252	02.106,07 MAINTENANCE OF EQUIPMENT 07. Maintenance of Equipment. The facility shall establish routine test, check and maintenance procedures for all equipment. This Rule is not met as evidenced by: Refer to F456 as it related to the clothes dryer lint	C 252	Refer to the Plan of Correction for F 456	

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C 252	Continued From page 2 compartment not being cleaned per manufacturers recommendations.	C 252	Refer to the Plan of Correction for F 312	
C 321	02.107,07,h h. Trays for patients/residents who need to be fed shall be set up only as there is someone available to do the feeding. This Rule is not met as evidenced by: Refer to F312 as it related to providing the necessary services to maintain good nutrition.	C 321		
C 325	02.107,08 FOOD SANITATION 08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Refer to F371 as it related to storing, preparing, distributing, and serving food under sanitary conditions.	C 325	Refer to the Plan of Correction for F 371	
C 405	02.120,05,e e. Patient/resident rooms shall be of sufficient size to allow not less than eighty (80) square feet of usable floor space per patient/resident in multiple-bed rooms. Private rooms shall have not less than one hundred (100) square feet of usable floor space. This Rule is not met as evidenced by:	C 405	Refer to the Plan of Correction for F 458	

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C 405	Continued From page 3 Refer to F458 as it related to room size.	C 405		
C 422	02.120,05,p,vii vii. On each patient/resident floor or nursing unit there shall be at least one (1) tub or shower for every twelve (12) licensed beds; one (1) toilet for every eight (8) licensed beds; and one (1) lavatory with mirror for every eight (8) licensed beds. Tubs, showers, and lavatories shall be connected to hot and cold running water. This Rule is not met as evidenced by: Based on observations and staff interviews, it was determined the facility did not ensure there were enough tub and/or showers for 94 licensed beds. The findings include: On 6/28/06 at approximately 10:30 am, the facility's tub/shower rooms were surveyed. Three tub or spa rooms and 1 shower room were observed on the 300 (1 tub and 1 spa room) and 100 (1 tub and 1 shower) units. A CNA was asked at approximately 11:30 am, if there were any more tub or showers at the facility. The CNA stated, "There is a tub between room 118 and 116." The bathroom shared by rooms 118 and 116, each licensed for two beds, had a tub. This bathing facility can only serve the four residents occupying rooms 118 and 116. On 6/30/06, at approximately 7:00 am, during the exit, the administrator was told the facility had only enough tubs/showers to accommodate 60 residents. The surveyor recommended the facility	C 422	The center has bid for a project to convert a resident room into a shower room as well as the current room where the beautician is working. This would provide the required bathing facilities for the center. It is anticipated that this project be completed during the final quarter of 2006. have requested a Waiver e-mailed supervisors	8-4-06

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	135093	A. BUILDING _____ B. WING _____	06/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN PARK HEALTHCARE	420 ROWE ST MOSCOW, ID 83843

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 422	Continued From page 4 discuss the situation with the Bureau of Facility Standards and request a waiver, if needed, or consider adding more tubs/showers in the event the census would increase. During an interview with the administrator on 7-12-06, the survey supervisor was told the facility has two bathing facilities on the 300 hall, and three bathing facilities on the 100 hall to serve the remaining 90 licensed beds left when the four beds in rooms 116 and 118 are removed from the count. There is also a bathing facility in the basement. The facility needs to have eight (8) bathing facilities for the 90 licensed beds excluding rooms 116 and 118.	C 422		
C 671	02.150,03,b b. Proper handling of dressings, linens and food, etc., by staff. This Rule is not met as evidenced by: Refer to F445 as it related to a sheet stored on the floor.	C 671	Refer to the Plan of Correction for F 445	
C 674	02.151,01 ACTIVITIES PROGRAM 151. ACTIVITIES PROGRAM. 01. Organized Program. There shall be an organized and supervised activity program appropriate to the needs and interests of each patient/resident. The program shall be designed to include a variety of processes and services which are designed to stimulate patients/residents to greater	C 674	Refer to the Plan of Correction for F 248	

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C 674	Continued From page 5 self-sufficiency, resumption of normal activities and maintenance of an optimal level of psychosocial functioning. It shall include recreation, therapeutic, leisure and religious activities. This Rule is not met as evidenced by: Refer to F248 as it related to the activity program.	C 674		
C 782	02.200,03,a,iv iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Refer to F280 as it relates to care plans not being reviewed and revised.	C 782	Refer to the Plan of Correction for F 280	
C 785	02.200,03,b,i i. Good grooming and cleanliness of body, skin, nails, hair, eyes, ears, and face, including the removal or shaving of hair in accordance with patient/resident wishes or as necessitated to prevent infection; This Rule is not met as evidenced by: Refer to F312 as it related to bathing.	C 785	Refer to the Plan of Correction for F 312	
C 789	02.200,03,b,v v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for	C 789	Refer to the Plan of Correction for F 314	

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C 789	Continued From page 6 exercise to promote circulation; This Rule is not met as evidenced by: Refer to F314 as it related to the pressure sores.	C 789		
C 790	02.200,03,b,vi vi. Protection from accident or injury; This Rule is not met as evidenced by: Refer to F324 as it related to the accidents and supervision.	C 790	Refer to the Plan of Correction for F 324	
C 838	02.201,02,l l. All medications in the facility shall be maintained in a locked cabinet located at, or convenient to, the nurses' station. Such cabinet shall be of adequate size, and locked when not in use. The key for the lock of this cabinet shall be carried only by licensed nursing personnel and/or the pharmacist. This Rule is not met as evidenced by: Refer to F281 as it related a bottle of eye drops left out, on top of the medication cart.	C 838	Refer to the Plan of Correction for F 281	
C 881	02.203,02 INDIVIDUAL MEDICAL RECORD 02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Refer to F514 as it related to the accuracy of	C 881	Refer to the Plan of Correction for F 514	

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C 881	Continued From page 7 clinical medical records.	C 881		